

**UNIVERSITY OF ALBERTA**

**PIMACESOWIN (TO MAKE YOUR OWN WAY):  
FIRST NATION GOVERNANCE THROUGH AN AUTONOMOUS  
NON-GOVERNMENT ORGANIZATION – THE EXPERIENCE OF THE  
PETER BALLANTYNE CREE NATION HEALTH SERVICES INC. IN  
NORTHERN SASKATCHEWAN**

by

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**A thesis submitted to the Faculty of Graduate Studies and Research  
in partial fulfillment of the requirements for the degree of**

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## **ABSTRACT**

This thesis examines the history and governance experiences of a First Nation Health organization in northern Saskatchewan. It describes the case study of the Peter Ballantyne Cree Nation Health Services Inc. within the context of a broader governance debate on the role of the State and civil society. It applies the integrated model which blends both views and acknowledges the continuing significance and link between the State and society in the management of public services. It suggests that society and First Nations, as the PBCN story demonstrates, can do a better job identifying and meeting their own needs through their own governance systems. The thesis also makes some recommendations and identifies topics for further study from the lessons learned in the governing experiences of the Peter Ballantyne Cree Nation Health Board.

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This thesis has truly been a marathon. It taught me invaluable lessons and provided me with opportunities to meet some wonderful and kind people along the way. Ninanaskomaw Kisemanito. I especially thank my supervisor Dr. Gurston Dacks for all his guidance, comments, revisions and support from start to finish and Dr. Linda Trimble who helped me get going. I also owe much thanks to the other exceptional scholars and faculty on my thesis committee as well as to my external examiner, Dr. Frances Abele, for taking the time to read the thesis and to provide valuable and much appreciated feedback. Thanks to Dr. Peter Butt, Dr. Vivian Ramsden, Dr. Bruce Waygood, Dr. Greg Poelzer and Dr. Audra Krueger for helping me and I will never forget the encouragement that I got from the PBCN Chief and Council, Health Board and staff.

I literally would not be here if it were not for the grace of my Saviour, Jesus Christ, and to him, well, I owe him everything. He got me through cancer, this thesis and everything else in between. His helping hands were in the form of family and friends. My nipapa, Oscar Beatty, taught me so much about God, loving others and the land - that with God nothing was impossible. My nimama, Jean Beatty, modeled persistence. After raising 13 children, she became the first woman to get her commercial fishing license - and that was over 20 years ago. Thanks as well to my 8 brothers and 4 sisters and their families, especially Nahum (everyone's big sister), and all my aunts (especially Aunt Sarah, my faithful cheerleader), uncles and bazillion cousins in Deschambault Lake and elsewhere. I know you are all happy that I am *finally* done. Last but not least, to my friends - I am afraid to name you in case I do not have any left - many thanks.

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## CHAPTER 1 INTRODUCTION

*"I think what needs to be done is to start a new beginning, a sense of telling the story from an aboriginal perspective and also a new beginning in which we have to acknowledge each other's existence."<sup>1</sup>*

### Introduction

The topic of this thesis is about an emerging corporate form of First Nation community governance. It is a story of the evolution and governance experiences of the Peter Ballantyne Cree Nation Health Services organization and its Board of directors. The story is told through a case study, which is a useful qualitative descriptive research method for studying and explaining a phenomenon within its total environment or in a more holistic way.<sup>2</sup> It observes the different aspects of governance by framing the discussions around its emerging themes of power and authority, relationships, accountability and political culture. The thesis framework examines the authority and role of the PB Health Board, the influences of other key players in health and more specifically, the processes that were used to balance all these influences in policy and decision making during the five years of managing the PB Health Transfer Agreement from 1995-2000.

In 1995, the PBCN<sup>3</sup> Chief and Council successfully negotiated the transfer of medical services for four of their eight communities in northeastern Saskatchewan from the Medical Services Branch of Health Canada (MSB)<sup>4</sup> and as part of the Transfer

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<sup>1</sup> Harper Elijah, *EarthKeeper, Canada's Environmental Magazine: Native Canadians*, January/February, Volume 11, Issue 111, Guelph, Ontario: 1992, 43.

<sup>2</sup> Remenyi Dan, Brian Williams, Arthur Money & Ethne Swartz, *Doing Research in Business and Management: An Introduction to Process and Method*, London: Sage Publications, 1998, 127

<sup>3</sup> PBCN refers to the Peter Ballantyne Cree Nation or Band government, PB Health refers to the health organization

<sup>4</sup> MSB refers to the Medical Services Branch of Health Canada, the federal department responsible for Indian Health policies and services



Agreement, incorporated an autonomous non-profit organization, separate from the Band administration, and under the control of a Board of community representatives, to manage and deliver the health services and programs specified under the Agreement. This study focuses on the governance, rather than the management and administration practices of the organization, a concept broadly described as the "pattern of authority within which decisions are made regarding fundamental activities,"<sup>5</sup> or as others put it, the "art of steering societies and organizations."<sup>6</sup> The governance theme provides a way of framing the analysis around the broader decisions, actions and leadership of the Board with respect to the way they directed or steered the organization. It deals with issues of power, relationships; accountability and political culture, all of which key concepts are often raised in governance literature.<sup>7</sup> Governance also goes beyond public administration and abstract constitutionalism to talk about how people gain a voice in the affairs of their community. This thesis therefore tells the story of the community Board rather than the story of the Chief and Council administration, although there are close linkages that are included in the analysis.

The concept of governance can have very broad applications with respect to the study of how governments and other institutions operate and their relationships with civil society. As a conceptual approach, governance provides a more holistic way of framing a

<sup>5</sup> Brodie Janine, Sandra Rein, eds., Critical Concepts: An Introduction to Politics, Third Edition, Toronto, Ontario: Pearson Prentice Hall, 2005, 80

<sup>6</sup> Institute on Governance, in collaboration with York University, CESO Aboriginal Services, Saskatchewan Federated Indian College, Understanding Governance in Strong Aboriginal Communities, Phase One: Principles and Practices From the Literature, October 12, 1999, ii, (<http://www.iog.ca/publications/strong-ab-gov.pdf>)

<sup>7</sup> Tim Plumptre, "Governance and Good Governance: International and Aboriginal Perspectives," Institute on Governance, December 03, 1999, 3; also Cassidy Frank, Robert L. Bish, Indian Government: Its Meaning in Practice, Lantzville, B.C.: Oolichan Books and the Institute for Research on Public Policy, 1989, p.x; also, Katherine A. Graham, "Urban Aboriginal Governance in Canada: Paradigms and

descriptive analysis of a First Nation institution like PB Health because it accentuates the important role relationships play in decision making and how power is exercised among key players, the nature of their accountability and the influence of political culture in this whole process. With the move away from state-led developments and governance in public affairs towards an emphasis on private sector and civil society involvement in government functions, the governance literature has also shifted more towards the roles and actions of non-government organizations delivering public services. These have sometimes been referred to as " 'the third sector,' neither prince (State) nor merchant (market),' "<sup>8</sup> and they include many types of entities such as registered non-profit service agencies, community groups, trade unions, cooperatives and others, including First Nation organizations such as PB Health.

The federal devolution policies of government services to First Nation control are usually bilateral Agreements with the Chief and Council administrations because they are the legally recognized government entities under federal legislation. This means that federal Health Agreements that involve corporate organizations like PB Health must be tripartite with the Chief and Council as signatories along with the corporation and federal department. Since 1986 when the federal Indian Health Transfer Policy came into force, by 1999, out of a total of 599 eligible communities in the MSB regions across Canada, 41% had signed transfer agreements through individual band or multi-community transfers and in Saskatchewan, out of a total of 83 eligible communities, 59 or 70% had

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Prospects," in John H. Hylton, ed., Aboriginal Self-Government in Canada: Current Trends and Issues, Second Edition, Saskatoon, Sask.: Purich Publishing Ltd., 1999, 377

<sup>8</sup> Turner Mark, David Hulme, Governance, Administration & Development: Making the State Work, West Hartford, Connecticut: Kumarian Press, Inc., 1997, 200

signed agreements, with 84% projected for 2004.<sup>9</sup> Since that time First Nation governments have continued to develop fairly extensive political and administrative capacities<sup>10</sup> at the Band level through broader coalitions or "aggregates"<sup>11</sup> at the regional, provincial and national levels.

In addition to federal government influence, demographic and other changes affecting First Nations peoples have also played a part in shaping Band governance. Demographic changes associated with the growing relocation of Band members to urban areas, the development of urban-based provincial and national First Nation political and service organizations, and the establishment of urban reserves has broadened the scope of influence and responsibilities of Band governments to members living both on and off reserve. Some Bands such as PBCN have electoral systems, which allow urban members to vote for Chief and Council, an urban councilor position was also added to the Council, and peripheral services are being added such as the family services coordinator position in PB Health. These urban linkages and services, however, remain secondary to reserve-based developments largely because of political and federal funding arrangements. After decades of experience in managing public services on their reserves with varying degrees of successes and failures, Bands have developed unique forms of governance or what Frank Cassidy and Robert Bish refer to as "Indian Government in practice." However, like other governing authorities in Canadian society, Band governments also face public legitimacy issues arising out of perceived failures in financial and political accountability.

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<sup>9</sup> Health Canada, Ten Years of Health Transfer: First Nation and Inuit Control, Ottawa: Minister of Public Works and Government Services Canada, 1999, 19

<sup>10</sup> Institute on Governance, Aggregation Among First Nations: A Handbook For Self-Government Negotiators, June 2001 1; WotherSpoon Terry, Vic Satzewich, First Nations: Race, Class and Gender Relations, 1993, 92; Cassidy Frank, Robert L. Bish, Indian Government: Its Meaning in Practice, 1989, 10

<sup>11</sup> Institute on Governance, Aggregation Among First Nations: A Handbook For Self-Government Negotiators, June 2001, 2



These concerns with political and financial accountability on the part of First Nation governments and the need to have a new kind of participatory politics in decision-making have been well documented by both Aboriginal and non-aboriginal scholars including Dan Smith,<sup>12</sup> Ronald Niezen,<sup>13</sup> Boldt (1993), Flanagan (2000), Noel Dyck (1991) and Cairns (2000). These concerns with accountability and governance have dominated the government agenda as well as exemplified in the Auditor General's reports of 1987, 1999 and 2002, which directed both the Department of Indian and Northern Affairs and the First Nations Inuit Health Branch of Health Canada to enforce stricter accountability measures in their funding Agreements.

These concerns were also a contributing factor in the corporate evolution of PBC Health and in response, the PBCN Chief and Council set up PBCN Health Services to deliver and administer health services to the communities of Pelican Narrows, Southend, Deschambault and Sturgeon Landing. The idea was to set up a more neutral health organization governed by a non-political Board separately incorporated and having an administration separate from the Band administration and its associated politics. Although PBCN consisted of 8 communities, the four Transfer communities had health clinics on reserve, and the rest were either off reserve or in urban centers and therefore provincially managed. Prior to the Health Transfer, the delivery of health services was fragmented among various agencies, although most were provided by the Medical

<sup>12</sup> Smith Dan, The Seventh Fire: The Struggle for Aboriginal Government, Toronto: Ontario: Key Porter Books Ltd., 1993, 238. Smith talks about the 62.1 % reserve vote against the Charlottetown Accord as indicative of the lack of trust in Indian leadership and the fear of change without safeguards.

<sup>13</sup> Niezen Ronald, "Telling a Message: Cree Perceptions of Custom and Administration, in The Canadian Journal of Native Studies, 13(2), 1993: 221-250, cautions against appropriation of culture in the goal to develop culturally appropriate institutions; similar concerns shared by Boldt Menno, Surviving as Indians: The Challenge of Self-

Services Branch of Health Canada. With Transfer, the leadership believed that they could improve the poor health conditions in the communities by having a more community-based health system that was directed by a board of directors made up of non-political community representatives. Their mandate was to develop a more comprehensive and culturally appropriate health system that would enhance community participation and local control over health programs.

What was unique about this governance model was that the Chief and Council set up an fiscally autonomous non-profit organization governed and managed by a community-representative board of directors as an alternative to the more common practice of having the funding managed and directed by a political administrative entity like a Band or Tribal Council administration.<sup>14</sup> It was a way of protecting health resources from the influences of a growing deficit in the Band administration as well as providing an alternative means of building political and administrative credibility for the band leadership in the eyes of the communities as well as the federal funding agencies. There was also strong political direction on the part of the leadership and the communities towards enhanced local control and ownership over the delivery of their own health services that favored the PBCN health board model over other potential external service delivery models such as the tribal council.

Historically, since the 1970s and 1980s, federal devolution policies in education, economic development, health and others, have enabled Saskatchewan Bands to develop

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Government, Toronto: University of Toronto Press, 1993 and Depew Robert. First Nations Organizations: An Analytic Framework, Ottawa, Ontario: Research & Analysis Directorate, Indian and Northern Affairs Canada, July 1994

<sup>14</sup> Indian and Northern Affairs Canada, report by Robert Depew, First Nations Organizations: An Analytic Framework, Ottawa: 1994, 4, where it noted that tribal councils were the main units of organization for the delivery of second and third level services. Also, a publication by Health Canada, Minister of Public Works

fairly extensive political and administrative capacities<sup>15</sup> at the Band administration levels, and at regional levels through broader coalitions or "aggregate"<sup>16</sup> entities like Tribal Councils or Grand Councils, and at the provincial and national levels with associations to political organizations such as the Federation of Saskatchewan Indian Nations and the Assembly of First Nations. At this point, the PBCN health governance model remains the only one of its kind where a community regional board has signed a tripartite health transfer agreement with the Chief and Council and MSB and has had over five years of governing and service delivery experience under this model which makes it a very interesting and informative example of a community-based form of governance.

The PBCN Health Transfer Agreement itself was also a unique model as far as health transfers were concerned. It was a five year tripartite Agreement involving the PBCN Chief and Council, the Peter Ballantyne Cree Nation Health Services Inc., and Medical Services Branch (MSB).<sup>17</sup> It was signed on March 17, 1995 and what was unique about it were the terms of reference around governance where the signatories agreed that "the delivery, administration, provision and control of health services by the Band,"<sup>18</sup> would be assigned to the board of directors of the new Health organization. Since that time, the PBCN Agreement has been renewed several times and the board

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and Government Services Canada, Ottawa: 1999, 26, lists the health transfers in Saskatchewan as being primarily with individual bands and tribal council administrations.

<sup>15</sup> Institute on Governance, Aggregation Among First Nations: A Handbook For Self-Government Negotiators, June 2001, 1; WotherSpoon Terry, Vic Satzewich, First Nations: Race, Class and Gender Relations, 1993, 92; Cassidy Frank, Robert L. Bish, Indian Government: Its Meaning in Practice, 1989, 10

<sup>16</sup> Institute on Governance, Aggregation Among First Nations: A Handbook For Self-Government Negotiators, June 2001, 2

<sup>17</sup> MSB is the acronym for Medical Services Branch of Health Canada, now called the First Nations Inuit Health Branch or FNIHB --- will be referred to as MSB throughout the thesis as well as "the state" arm for Indian health policy.

<sup>18</sup> The PBCN Health Service Transfer Agreement, 1995, 3



structure has remained relatively unchanged which suggests that this form of community governance worked for them, and it also raises the issue of "how did it work?"

To address that issue, the general research question in the case study asks what the experience of the board and organization after five years of operation under the PBCN model was. The specific research questions ask: Why did it evolve the way it did? What were the advantages and challenges of the model and what implications does it suggest for further study? In discussing the advantages and challenges, focus will be placed upon the governing relationships and interactions between the Board and the other partners in the PBCN transfer agreement - the community, the Chief and Council and the State (Medical Services Branch, Health Canada).

The theme of the case study suggests that in the case of the Peter Ballantyne Cree Nation, the decision by the Chief and Council to set up a regional autonomous NGO governed by a community-representative health board to manage, control and deliver health services to their communities offered significant advantages for enhancing the overall quality of their health system as well as helping build more capacity in local governance and administration. The case study will inform a gap in the existing literature on First Nation governance. While much scholarly work has been done on the broader issues of Aboriginal Rights and Self-Government, there has been little empirical research done on the governance experiences of individual First Nations organizations in Canada which for the most part have evolved through their day-to-day experiences in governing, creating policies and delivering various public services in their communities.<sup>19</sup>

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<sup>19</sup> Young David E. and Leonard Smith, 1992, Robert Depew 1994, T.K. Young, 1994, Noel Dyck, 1991, Frank Cassidy and Robert L. Bish, 1989, Wayne Warry 2000, John H. Hylton, 1999

In relation to where the PBCN Health Board story fits in the context of the broader issues of self-government in Canada, there is no question that the case study is not an example of self-government, at least not in reference to any form of sovereignty that is the usual perception when self government is raised. It is an administrative arrangement that can at best be perceived as a preparatory step towards self-government. There are therefore some limits to the relevance of the case to other First Nations who may have their own ideas about administrative arrangements with the federal government. While some might suggest that taking health transfer is settling under a continuing colonial regime, for the PBCN Band, there really was no other alternative besides the status quo, which was to allow MSB or some other external agency to continue to administer health services for them. The Transfer allowed the PBCN Band some administrative control and management over their own health services using delivery models they choose, even if they were still being monitored by MSB under the Agreement.

The case study may also have policy implications for other First Nations considering health transfer and upon the health renewal initiatives by Health Canada in their endeavors to better manage public funds targeted for First Nations and Inuit people. The complex issues associated with healthcare such as affordability, accountability and sustainability are a concern for all.<sup>20</sup> About \$1.0 billion was spent by Health Canada in 1998-99 on community-based and other related health programs to First Nation and Inuit people. These include the provisions under the non-insured health benefits program (NIHB) which covers certain medical benefits for First Nations or Status Indians that are

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<sup>20</sup> Health Canada, *Ten Years of Health Transfer: First Nation and Inuit Control*, Ottawa: Minister of Public Works and Government Services Canada, 1999, 19

not covered under standard Medicare provisions for things such as prescription drugs, dental care, medical transportation, optometry and others, all of which are managed through various national policies and approved lists.<sup>21</sup>

The case study is limited in that it is a single case study and therefore, cannot be used as a general or universal application in the generation of some new theory around First Nation governance or to serve as a standardized governance model for other First Nations. However, the value to the case study is that the experiences, strengths and challenges and lessons learned by the PBCN people will be useful in terms of informing through example, generating ideas and options and communicating lessons. It will hopefully inspire more scholarly interest in studying and expanding the scope of knowledge around First Nation governance by examining other kinds of governance systems that have developed in First Nation communities. As more work of this nature is done, the context provided by understanding governance in praxis will supplement what exists in theory thereby providing a more balanced reflection of First Nation self-government.

### **Thesis organization**

The first chapter provides an introduction to the purpose and significance of the case study. It describes the governance approach that was used to address the research question by framing the analysis around the decisions and actions of the Board and how

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<sup>21</sup> Minister of Public Works and Government Services Canada, Report of the Auditor General of Canada to the House of Commons, Chapter 13: Health Canada-First Nations Health, Ottawa, 1997: 13-34, and 2000 Report of the Auditor General of Canada, found on Health Canada website: <http://www.oag-bvg.gc.ca/domino/reports.nsf/html/0015ce.html>



they dealt with the complex issues of power and authority, relationships, accountability and political culture. It also provides a summary of PBCN history and traditional territories as a way of setting a contextual background. It then describes the research and data collection methods used in the case study all of which utilized literature reviews and a combination of internal PBCN Health documents and secondary source documents pertaining to the organization. While I had a strong "pre-understanding" or knowledge of the organization as a former employee, my descriptions of the case primarily drew from internal and external source documents that were triangulated to ensure validity and reliability. A list of definitions and acronyms used in the study are provided at the end of this chapter.

The second chapter provides an overview on the development and trends found in governance literature from the State, society and First Nation perspectives. It discusses key concepts in governance theory that were developed to help explain the changing relationships between the State and civil society and/or between the state and private sector. The purpose of the literature scan was not only to determine what was available or missing in the governance literature, but also to help develop a framework and an approach for the case study. In the end, an integrated approach was used to frame the study around the relationships and interactions between the Board and its stakeholders that allowed me to discuss other issues involved in governance such as power, authority, accountability and political culture. The integrated approach focuses on the growing influence and involvement of the various sectors of civil society such as non-profit corporations, special interest groups and the emerging First Nation government organizations in state governance and public service delivery. Devolution is viewed in

terms of adaptation by the central government to a changing environment rather than viewing it as a "withering away" or "hollowing out" of traditional state authority.

Devolution implies that the greater involvement of citizens and non-government agencies in public services is good governance where both the State and society can both maintain integral roles and functions. For First Nations, transfer policies are linked to the federal policy that recognized First Nation self-government and because health service issues and delivery cut across jurisdictional lines, cooperation is essential between First Nations and the other levels of government and health organizations.<sup>22</sup>

The third chapter describes PBCN history and evolution of their governance systems beginning with their traditional governance systems which, like most foraging societies, were based upon spiritual values and beliefs, the importance of family and kinship relations, and communal customs such as sharing, helping others in need and cooperation. It describes the changes and eventual displacement of that system under the influences of the fur trade, the churches and the federal state, and the emergence of the contemporary "Band government" system under the Indian Act. It describes the changing political culture of the PBCN communities and how the contemporary Band governance system and political culture influenced the evolution of PB Health.

The fourth chapter focuses on the historical evolution of the federal health system with respect to Indian health policy and service delivery and how that influenced the PBCN situation. It discusses issues of jurisdiction and responsibility between the various levels of government, the trend towards more community control over programs and services, the health transfer policy, and the factors that helped influence the decision by

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<sup>22</sup> Abele Frances. "Urgent Need, Serious Opportunity: Towards a New Social Model for Canada's Aboriginal Peoples." CPRN Social Architecture Papers: Research Report F/39 Family Network. 2004.

the PBCN leadership to enter into the pre-transfer process which resulted in the signing of the PBCN health transfer agreement.

The fifth chapter describes the PBCN Health Transfer Agreement and the general terms and requirements of the PB Board. It looks at the pre-Transfer and implementation processes of the Transfer. It describes the mission and purpose of Transfer and the policy direction outlined in the PBCN Community Health Care Plan. The Board selection process is explained along with the power and authority of the Board, their accountability requirements, relationships with other key stakeholders and political cultural expectations of the communities.

The sixth chapter describes the organizational evolution and governance experiences of the organization in the first year of health transfer. The first year was possibly the most significant year for the Board in the developmental history of the organization. It was a time of testing for Board decisions, rapid organizational growth and because of the political uncertainty with respect to management capacity, they had to win the confidence of their main stakeholders, and they had to facilitate change with respect to how health services were being delivered. The chapter describes the transition process; the governance structure and operations of the Board; the influence of kinship political culture on Board governance; the capacity building initiatives for the Board, organization and community; the distribution of power and authority between the Board and its primary stakeholders and a discussion on how the Board balanced the various interests in the governing of the organization.

Chapter Seven describes the implementation of the Transfer during the last four years between 1996-2000. It describes the relations and interactions between the PBCN



health Board and key stakeholders in the health governance process, namely the Health administration, the community, the Chief and Council and the State (MSB). These are discussed in relation to the themes of power and authority, accountability and political culture. It examines the Board-community relations with reference to the community-based health committees, the interagency networks in the communities and the individual community members. It describes the Board-Chief and Council relations at the regional and community levels with respect to roles, functions and protocols. It also describes the relations between the PBCN board and MSB with respect to the residual roles, functions and interactions of the federal government in the delivery of health services to the PBCN communities.

Chapter eight provides conclusions about the PB Health Transfer governance experience after five years of health transfer and implications for further study. The results of the Transfer are described along with lessons learned and research gaps that remain to be filled. The governance approach using the themes of power and authority, relations, accountability and political culture is analyzed in terms of usefulness. Conclusions about these themes are drawn with respect to changes in the relations and interactions between the Board and their primary stakeholders (Chief and Council, Health administration, community, MSB). Findings from various external evaluation surveys on the PB transfer also provide supplementary information about community opinions around personal health needs, the quality of health services provided by PBCN Health, and recommendations for improvement. These were useful references from which to reflect upon the general impact of the health model upon the communities and people's

perceptions around the health model. Topics for further study arising from this case study are also provided.

### **The Peter Ballantyne Cree Nation Profile**

An introductory profile of the Peter Ballantyne Cree Nation and their communities provides helpful background to the evolution of the PBCN health organization. According to oral history and documented scholarship, the ancestors of the PBCN people were most likely part of the western Woods Cree, more specifically, the Rock Cree or Misinipi Cree or as translated in Cree, the "Asiniskawithininiwak,"<sup>23</sup> or spelled another way, "Assin'skowitniwak,"<sup>24</sup> who spoke the "th" dialect and occupied the Churchill River drainage region of northern Saskatchewan and Manitoba. The Woodland Cree traditionally occupied a large territory spanning the north-central regions from La Ronge and Montreal Lake to the northeastern regions of Brochet, Southern Indian Lake, and Nelson House in Manitoba.<sup>25</sup>

### *PBCN Communities and Population*

Today, the PBCN is a multi-community band made up of eight communities with a combined membership of over 7300 people,<sup>26</sup> over half residing on reserve. It is one of

<sup>23</sup> Brightman Robert E., *Grateful Prey: Rock Cree Human-Animal Relationships*, Berkeley and Los Angeles, California: University of California Press, 1993, 5

<sup>24</sup> Merasty Ron, *A Portrait of The Peter Ballantyne Cree Nation*, Prince Albert, Saskatchewan: taken from a binder of Merasty's unpublished personal writings and archival material on PBCN history, 1

<sup>25</sup> Brightman Robert E., *Grateful Prey: Rock Cree Human-Animal Relationships*, Berkeley and Los Angeles, California: University of California Press, 1993 quoting James G.E. Smith., 1981. "Western Woods Cree" in J.Helm, ed., *Handbook of North American Indians*. Vol. 6, Subarctic. Washington D.C.: Smithsonian Institution

<sup>26</sup> Prince Albert Tribal Council data on PBCN's registered population as of August 2003. Website: [http://sdiprod2.inac.gc.ca/FNProfiles\\_General Information.asp?BAND\\_NUMBE....](http://sdiprod2.inac.gc.ca/FNProfiles_General%20Information.asp?BAND_NUMBE....), note: Population

the ten largest Bands in Canada.<sup>27</sup> The first Chief of the PBCN, Peter Ballendine (now Ballantyne), signed an adhesion to Treaty #6 on September 3, 1878. The PBCN territory is large covering the northeastern and north-central part of Saskatchewan, 454 km north of Prince Albert and 508 km east to the Flin Flon, Manitoba border.<sup>28</sup> Most of the PBCN membership population live in the seven northern communities of Pelican Narrows, Deschambault Lake, Southend Reindeer Lake, Sturgeon Landing, Sandy Bay, Kinoosao and many others reside in larger urban centers such as La Ronge, Prince Albert, Saskatoon and Regina.

#### *PBCN Traditional Governance*

While the Peter Ballantyne Cree Nation is generally perceived as consisting of politically homogenous communities under a multi-community band structure, their history is one of scattered and nomadic hunting, fishing and trapping societies consisting of households of closely-related families.<sup>29</sup> As was the case in many foraging societies, the family households were most likely the primary means of traditional political authority and social control prior to the band government system.<sup>30</sup> The political cultures or the shared political values and belief systems of these traditional societies have

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statistics vary; according to the Indian Affairs 2000 Registered Indian Population, PBCN is listed at 6901; and as of 2004, 7460

<sup>27</sup> Information Management Branch, Department of Indian Affairs and Northern Development, Registered Indian Population By Sex and Residence 2000, Ottawa: Minister of Public Works and Government Services Canada, 2001

<sup>28</sup> PBCN Health Services Inc., Home and Community Care Service Delivery Plan, May 2001, Prince Albert, Saskatchewan, 2001, 5.

<sup>29</sup> Buckley, Helen and Kew J., Hawley John, The Indians and Metis of Northern Saskatchewan: A Report on Economic and Social Development, Saskatoon: Center for Community Studies, 1963; also, Ballantyne Phillip, et al. Aski-Puko: The Land Alone, Saskatoon: Office of the Treaty Commissioner, 1976

<sup>30</sup> Leacock Eleanor, Richard Lee, eds. Politics and History in Band Societies, Cambridge: Cambridge University Press: 1982, 8,9



generally been characterized as "communal,"<sup>31</sup> "cosmocentric,"<sup>32</sup> "cooperative bunches,"<sup>33</sup> "kinship-based,"<sup>34</sup> and "egalitarian."<sup>35</sup>

Scholars suggest that the support and values of the kinship groups were essential for survival in the north and that they demonstrated an adaptation to the environment. The political cultural values included respect and dependency on the Creator, self-reliance, cooperation, sharing, generosity and hospitality.<sup>36</sup> While leadership and decision-making were flexible and directed by group consensus, families were dominated by patriarchs whose authority was earned through age and the demonstration of various personal skills such as diplomacy, hunting and trapping expertise, the ability to look after their families, and for some, special shamanistic abilities.<sup>37</sup>

While these cultural values may be less evident today, they continue to be important in the political systems of the communities as evidenced in the election of leaders from large families and the influence of respected elders and skilled individuals in decision-making.<sup>38</sup>

#### *Contemporary PBCN Governance*

The PBCN Band government is a regional structure made up of one chief and 14 councilors, making a council quorum at 7/15. Although the election system is by band

<sup>31</sup> Poelzer Dolores T., Irene Poelzer, *In Our Own Words: Northern Saskatchewan Metis Women Speak Out*, Lindenblatt & Hamonic, Saskatoon: 1986, 3

<sup>32</sup> Boldt Menno and J. Anthony Long, "Tribal Philosophies and The Canadian Charter of Rights and Freedoms," in *The First Ones: Readings in Indian/Native Studies*, editors, David R. Miller, et al., SIFC Press, Piapot Reserve #75: 1992, 329

<sup>33</sup> Lithman Yngve Georg in Beatty Bonita, Unpublished MA Thesis, *The Transformation of Indian Political Culture in Northern Saskatchewan*, Regina, Saskatchewan: University of Regina, 1996, 19

<sup>34</sup> Brizinski Peggy in Beatty, *ibid*, 22

<sup>35</sup> Leacock Eleanor in Beatty, *ibid*, 22

<sup>36</sup> Young T. Kue, *Health Care and Cultural Change: The Indian Experience in the Central Subarctic*, Toronto: University of Toronto Press, 1988, 14

<sup>37</sup> Brightman Robert E., *Grateful Prey: Rock Cree Human-Animal Relationships*, Berkeley, California: University of California, 1993, 11

<sup>38</sup> Young T. Kue, *op cit.*, 1988, 14

custom, the democratic voting system of the Indian Act has been adopted with minor variations. Each of the communities have a certain number of councilors representing them depending on their population. Pelican Narrows has 6 councilors; Deschambault Lake has 2; Southend has 2; Sturgeon Landing has 1; Denare Beach has 1, and Sandy Bay has 2.<sup>39</sup> The chief is elected at large whereas local communities can only elect their own councilors. All serve a two-year term of office. The Band administration is centralized in Pelican Narrows with a sub-office in Prince Albert. The communities of Deschambault and Southend also have their own local administrations but are tied into the Band's global funding agreement with Indian Affairs. The Band administration is responsible for coordinating and managing most of the public services for the communities such as education, economic development, housing, capital, social development, community infrastructure, land entitlement and other special projects through various service agreements. The band administrations of Deschambault Lake and Southend manage many of these programs for themselves, but are still connected to the central administration.<sup>40</sup> The link between the administration and band governance has been direct with the Chief and council assigning various portfolios such as education, economic development and health to specific councilors. However, in the mid 1990s, autonomous regional boards, such as the PBCN Health Board, were set up largely in response to the uncertainties created out of the Band's fiscal problems as well as a growing political push for increased local control.

#### *PBCN Demographic Summary*

<sup>39</sup> Department of Indian Affairs and Northern Development, *First Nation Profiles*, 1996 Data; Website: [http://sdiprod2.inac.gc.ca/FNProfiles/FNProfiles\\_PrintForm.asp?BAND\\_NUMBER=355...](http://sdiprod2.inac.gc.ca/FNProfiles/FNProfiles_PrintForm.asp?BAND_NUMBER=355...)

<sup>40</sup> *PBCN Health Care Needs Assessment For the Members of the Peter Ballantyne Cree Nation*, Prince Albert: PBCN, 1991, 11-12

The current demographic trends for the PBCN communities resemble the demographic trends of the northern population as a whole and are summarized as follows:

- The "northern region" is officially recognized by all levels of government as encompassing the northern half of Saskatchewan, approximately 300,000 square kilometers of forests and lakes.<sup>41</sup> All PBCN communities, except for Kinoosao, are accessible by gravel and paved roads.
- Census 2001 suggests that the majority of the northern populations are aboriginal, where over 50% are First Nation or status Indians.<sup>42</sup> The northern population is projected to grow by 38% in the next 15 years compared to 1% for Saskatchewan as a whole.<sup>43</sup>
- The PBCN average annual population growth varies between 3 to 4%<sup>44</sup>, which is reflective of the provincial aboriginal population annual growth rate at 3.2%.<sup>45</sup>
- The northern population is young with 45% under age 20 compared to 28% in the rest of the province. Only 19% are over age 44 compared to 36% provincially. Youth aged 15 to 24 are more disadvantaged than their counterparts in the rest of Saskatchewan – more teen pregnancies, more school dropouts, fewer are active in the labor force and facing high unemployment.<sup>46</sup>
- Although there has been improvement in education levels in the past 5 years,<sup>47</sup> the north continues to experience lower educational attainment. Over 45% between ages 20 to 64 had less than a high school certificate compared to 27.6% in Saskatchewan.<sup>48</sup>
- According to the 1996 Census data, for the PBCN population age 15 years and over, 33% had less than grade 9; 37% had or were in grades 9 to 13, 6% had a trades certificate or diploma, 16% had other non-university education, and 8 % had university education.<sup>49</sup>

<sup>41</sup> Northlands College, The Northern Labour Market Committee, Saskatchewan Learning, Northern Saskatchewan: Regional Training Needs Assessment Report, Summer 2003, La Ronge, Saskatchewan: 2003, 8

<sup>42</sup> *ibid*, 11

<sup>43</sup> *ibid*, 14

<sup>44</sup> Peter Ballantyne Health Services Inc., Health Transfer Renewal, April 5, 2000, Prince Albert, Sask: 2000, an appendix attachment showing the PBCN Transfer Population Graph.

<sup>45</sup> Aboriginal Canada Portal, 2003 Report on Aboriginal Community Connectivity Infrastructure, .2 website: <http://www.aboriginalcanada.gc.ca/abdt/interface/interface2.nsf/vSSGBasic/ao28085e.htm>

<sup>46</sup> Northlands College, *op.cit.*, 2003, pg.4, pg 11

<sup>47</sup> Northlands College, *ibid.*, 2003,4

<sup>48</sup> *ibid*, 18

<sup>49</sup> Department of Indian Affairs and Northern Development, First Nation Profiles, 1996 Data, *op.cit.*, 2,3



- There are high unemployment and lower wages for existing jobs in the north; many of the jobs are part-time or seasonal. In 2001, only 53% of the 20,220 adults age 15 and over were active in the labor force (employed or looking for work) compared to 66% in the province.<sup>50</sup> For the northern labor force (age 15+), close to 41% are employed compared to 63% in Saskatchewan. The unemployment rate in the north is estimated at 24% or 4 times the provincial average.<sup>51</sup>
- Census data suggests that median income for northern families from 1996-2001 was lowest in the province at \$27,323, compared to median family incomes in Regina at \$56,908.<sup>52</sup> For PBCN communities, estimated median family incomes for 3 of the larger communities at \$21,052; a little under the northern average.<sup>53</sup> (Median income refers to halfway point for families with higher and lower incomes)
- It is estimated that about 25% of all adults and children living in the north receive either provincial or First Nation social assistance income.<sup>54</sup>

### The Governance Approach

The concept of governance is concerned with studying the interactions among structures, processes, traditions that determine how power is organized, how decisions are taken and how citizens or other stakeholders have their say. It is generally about power, relationships and accountability.<sup>55</sup> The key to better understanding PBCN Health involves consideration of the relationships and issues around the distribution and balancing of political and administrative power in the evolution of the Board and its relations and interactions with the State, the Chief and Council, and community. It basically describes how the board through the organization balanced and managed these relationships to meet the objectives and responsibilities under the Health Transfer

<sup>50</sup> Northlands College, op.cit., 19

<sup>51</sup> ibid, 20

<sup>52</sup> ibid., 22

<sup>53</sup> 2001 Community Profile, for Pelican Narrows, Deschambault and Southend, website: <http://www12.statcan.ca/English/profil01/Details/details1edu.cfm?SEARCH=BEGINS&P...>

<sup>54</sup> Northlands College, op.cit., 23

<sup>55</sup> Tim Plumptre, *Governance and Good Governance: International and Aboriginal Perspectives*, Institute on Governance, December 03, 1999, 3.

Agreement. Moving from a previous position where health governance and administration had been dominated by the larger political institutions of the Chief and Council and the State, with limited input by the community, the new single-window approach through an autonomous NGO and a community board was a unique and untried method of governance and service delivery for PBCN.

The governance approach used here applies an integrated perspective that blends both the state-centric and society-centered views in organizational analysis. It acknowledges the strong influence of the state on self-government and the equally strong influence of First Nation community politics. It examines the broader processes of interaction and participation in First Nation communities between a non-profit service delivery agency and the public interests to which it is accountable as represented by the state, chief and council, and the community and how these relationships influenced their decision-making processes,<sup>56</sup> as opposed to the more narrow approach on government institutions and their bureaucracies.<sup>57</sup>

The integrated view suggests that the governance environment that is being created through devolution is distributed governance where power and authority are distributed through a variety of institutional arrangements between the State and First Nation governments. What forms these arrangements take and how they are played out in

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<sup>56</sup> Leo Panitch on civic society has influence, Paul Sabatier (1988) Michael Howlett, Jeremy Rayner on Advocacy and Policy Networks, (1988), scholarship on new social movements such as social feminism, Sandra Burt (1990), Sally Weaver (1993), J. Brodie (1985) etc. and Aboriginal politics, Robert Depew (1994). Frank Cassidy, Robert L. Bish (1989), Alan Cairns (2000) Peter. D Elias (1991), Linda T. Smith (1999), Evelyn J. Peters (1986), etc.

<sup>57</sup> Governance in terms of the state institutional perspective –capacity, influences,- Theda Skocpol, Kenneth Finegold (1982), market influence, Charles Lindblom (1982), global influences, Peter Gourevitch, E.H. Fry (1998), Gilles Paquet, David Hayne (2000), and public administration scholarship, Ken Kernaghan (1995), Peter Drucker (1995), Judith Gruber (1988), H.H. Gerth and C. Wright Mills in *From Max Weber*, (1946), Mark Turner, D. Hulme (1997), Gilles Paquet, D. Hayne (2000), and aboriginal-state relations, A. Cairns, T. Flanagan (2000), and others

a First Nation context provides an Aboriginal element to the general application of governance to governing institutions in the broader society. The concept of governance is generally concerned with the "art of steering societies and organizations,"<sup>58</sup> and it involves the coordination of relationships and interactions within certain environments. It is about the strategies involved in directional planning, who is involved and in what capacity. It can be applied to any form of collection action, including the study of First Nation organizations.

It is anticipated that within this decentralized environment, the First Nations are more likely to develop institutions that are more community responsive, more horizontal in structure, where the management practices are guided by principles of team-building, partnerships, consensus decision-making, transparency, accountability and where community participation is integrated throughout the whole structure to better reflect the culture of the community. In this environment, both the State and the First Nations are seen to be going through a period of transformation, not decline, where both are adapting and forging new relationships and new roles through the process of trying to find the best means for delivering public services.

A broad understanding of Governance has to do with institutional and societal relationships and how the state coordinates or steers these relations. The literature on governance suggests that the devolution of public programs and services from the state to non-government agencies or NGOs has changed the role of the state from direct control over the steering of society and public institutions to a more coordinating role in a new distributed or shared governance arena. It implies that a distributed form of governance is

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<sup>58</sup> Plumptre Tim, John Graham, Governance and Good Governance: International and Aboriginal Perspectives, Institute on Governance, December 03, 1999, 3



good governance in that allows citizens to have more direct input in the governing and delivery of public services through their involvement with non-government service organizations. The assumption is that citizens and groups have the capacity and can do a better job in articulating their needs and addressing them through some form of autonomous process apart from government.

Governance has many definitions, and because it is associated with the functions of governing, it is often confused with government in both general and aboriginal<sup>59</sup> governance literature. One definition tends to focus on the formal instruments of the state system and how it responds to its external environment; the other definition refers to the conceptual representation of a coordination function or a "steering" of social systems by the state and/or non-government agencies.<sup>60</sup> Most scholars on governance agree that it has to do with making decisions about setting and controlling a direction for society. Even the Oxford dictionary uses the function of governing and control to define both government and governance, but it does add "system" to government, thereby implying a distinction between form and function. The vague definition of governance has several negative effects for theoretical analysis. It narrows the scope to formal government structures, thereby ignoring or minimizing the influence of other non-government structures engaged in delivering public services. It also makes it hard to formulate conceptual categories that are comprehensive enough for analysis or to develop

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<sup>59</sup> The terms Aboriginal, Indian, native are used interchangeably in the literature to refer to indigenous peoples; I myself use aboriginal and First Nation interchangeably to refer to First Nations under the Indian Act.

<sup>60</sup> Robert Depew, DIAND Report, (1994)

measurable variables to determine related issues such as what constitutes good governance.<sup>61</sup>

Nevertheless, a good definition is needed to explain things properly and the definition which involves the notion of steering is the preferred approach here because it focuses on the relationships involved in the practice of governance as well as how the steering is done, whether it is from the perspective of the larger Canadian State or a First Nation government or non-government agency. This integration of form and function provides a more realistic picture. The application of the 'steering' concept in the study of the PBCN Health organization helps to present a way of looking at the whole picture and its constituent parts. While scholars have their own versions of what these constituent parts are depending on what they are trying to explain, my version builds upon the issues raised by Plumptre and Graham. It will examine the issues of power, relations, accountability and political culture within the context of the experiences of the organization with respect to the balancing of the interests and expectations of the community, the Chief and Council and the State.

Tim Plumptre and John Graham define governance as "the art of steering societies and organizations...it involves the interactions among structures, processes, traditions that determine how power is organized, how decisions are taken, and how citizens or other stakeholders have their say."<sup>62</sup> They raise issues of power, relationships and accountability that deal with questions of who has influence, who decides and how decision-makers are held accountable. Other scholars on Indian government also identify variations of the same themes in governance that involve power, relationships,

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<sup>61</sup> Tim Plumptre, John Graham, Institute on Governance, 1999; Robert Depew, DIAND Report, 1994

accountability, service delivery and finance. Frank Cassidy and Robert Bish refer to issues involving citizenship, policy-making, service production and delivery and finance.<sup>63</sup> Katherine Graham in her study of urban aboriginal governance suggests it is about institutions, services and political arrangements.<sup>64</sup> Robert Depew suggests that the essential components include latent formations, manifest formations, policy issues and the environment.<sup>65</sup>

In retrospect and in examining internal records of PBCN Health,<sup>66</sup> I found that most of these issues affected the organization in terms of concerns with institutional capacity and sustainability, increased community participation in decision-making, community-based development, political and financial accountability, and improved service delivery. All of these had to do with how the NGO balanced and coordinated the relationships and interests in the communities it was serving, which led to questions on governance such as: Who are the stakeholders and what is the scope of their influence? Who makes decisions and how are decisions made and implemented? How are decision-makers held accountable? How is conflict resolved and how is change managed?

Although aboriginal governance is being debated and gaining recognition at a theoretical level by scholars, political leaders and government policy makers across the

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<sup>62</sup> Plumptre Tim, John Graham, Governance and Good Governance: International and Aboriginal Perspectives, Institute on Governance, December 03, 1999, 3

<sup>63</sup> Cassidy Frank, Robert L. Bish, Indian Government: Its Meaning in Practice, Lantzville, B.C.: Oolichan Books and the Institute for Research on Public Policy, 1989, p.x

<sup>64</sup> Graham Katherine A., "Urban Aboriginal Governance in Canada: Paradigms and Prospects," in John H. Hylton, ed., Aboriginal Self-Government in Canada: Current Trends and Issues, Second Edition, Saskatoon, Sask: Purich Publishing Ltd., 1999, 377

<sup>65</sup> Depew Robert, First Nations Organizations: An Analytic Framework, Ottawa: Research & Analysis Directorate, DIAND, 1994, 70

<sup>66</sup> The PBCN Health Service Inc., Personnel Manual, Administration Manual, Directional Plan, Community Development Plan.



country,<sup>67</sup> it is at the level of the First Nation community that the meaning and practice are being developed and where it is most visible. As scholars Cassidy and Bish suggest, it is the varied patterns of service delivery in reserves that reflect the "emerging nature of Indian government in practice: while seeking a change in the basic design of Canadian federalism, Indian peoples and their governments have taken advantage of the possibilities in the current federal-provincial framework to realize and extend their vision of Indian government."<sup>68</sup> Case studies on First Nations governance practices in service delivery and their relationships with the community, will as Depew says, not only "open new intellectual space,"<sup>69</sup> for scholars to examine how First Nation governments influence or are influenced by government policies, they would also add a practical component to enhance developing theories on First Nation governance.

Most scholars agree that there is no universal model of aboriginal governance because each First Nation has its own distinct way of steering its society and institutions,<sup>70</sup> but there is agreement that in traditional societies, prior to representative band governments, the political culture of Indian government emphasized direct citizen involvement in political decision-making through customary practices, such as consensus, elders advice and open meetings, and these are often demonstrated through their languages, as in the Cree term "pimacesowin", which means "our way of life."

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<sup>67</sup> Plumptre Tim, John Graham, refer to over 200 treaty commission tables currently negotiating self-government issues, like governance, across Canada.

<sup>68</sup> Cassidy Frank, Robert L. Bish, *Indian Government: Its Meaning in Practice*, Lantzville, B.C., Oolichan Books and the Institute For Research on Public Policy, 1989, 156

<sup>69</sup> Plumptre Tim, John Graham, *Governance and Good Governance: International and Aboriginal Perspectives*, Ottawa: Institute on Governance, December 3, 1999, 14

<sup>70</sup> Mercredi Ovide, Turpel Mary Ellen, 1994; Frank Cassidy, Robert Bish, 1989; Jill Oakes, Rick Riewe, et al., 2001; Wayne Warry, 1998, Robert Depew, 1994; Tim Plumptre and John Graham, Dec 3, 1999; John H. Hylton (ed) 1994; Menno Boldt, 1993; Yngve Georg Lithman (1984)

What remains to be seen is whether and to what level this direct form of consensus participation by band members in decision-making is evident in PBCN Health.

### DATA COLLECTION

In developing the case study of PB Health governance, I applied a "retrospective action research"<sup>71</sup> process which is a qualitative methodology that tries to get a holistic view of a specific phenomenon or series of events by taking into consideration its many different elements, examining them in relation to each other, viewing the process from its total environment, including the researcher's personal experience in the development of the organization. Action research refers to the active participation of the researcher in these processes through employment or other similar experiences that provide the researcher with a capacity for a deeper understanding of the situation. Retrospection has to do with looking back at past events and analyzing the experiences of the case within a certain period, which in this case, is 1995-2000, a period when I was employed by the organization as a director of community development. My role during that period was to set up the health systems in the communities. These experiences while invaluable in their own right did not play a significant part in my thesis work later. The thesis is about Board governance and because it is based solely on official documents, any reference that I may have made to any of my own personal work notes taken during the course of my employment were for reference only to help me remember "in retrospect" some of the background surrounding certain events in the Board minutes and PB Health reports. In that sense, they helped clarify some of the official documents that I could not understand. The PB documents were triangulated with other external data sources such as evaluations

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<sup>71</sup> Gummesson Evert, *Qualitative Methods in Management Research: Second Edition*, Thousand Oaks, California: Sage Publications Inc., 2000, 122

and conference findings for validity purposes. My analysis is based on the information I gathered from public documents, such as reports, news items, conference summaries, and from internal PB Health documents such as Board minutes and program reports. A Board motion provided the approval for me to use the relevant internal documents that I needed for the purposes of my thesis research.

A case study refers to the collection, presentation and triangulation of multiple sources of material about a "contemporary phenomenon within its real life context,"<sup>72</sup> and it is used here to tell the PB Health story or narrative through the emerging themes found in the literature reviews on governance involving issues of power and authority, relationships, accountability and political culture. It is assumed that bias can be minimized by the triangulation of information or "getting multiple sources of evidence that support all the important assertions,"<sup>73</sup> and subsequently, the more evidence can be gathered, the greater the degree of validity. Triangulation arose from the ethical need to validate processes, and in case studies, using multiple sources of data could do this validation.<sup>74</sup> In qualitative research, such as case studies, the search for reliability and validity standards is a concern since it is difficult to measure and interpret complex information, particularly when the study is about systems, processes and human dynamics.<sup>75</sup> The triangulation of data sources in the case of PB Health incorporates both internal and external materials as a means of enhancing the validation of research

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<sup>72</sup> Remenyi Dan, Brian Williams, Arthur Money, & Ethne Swartz, Doing Research in Business and Management: An Introduction to Process and Method, Sage Publications, London: 1998, 50, quoting Yin (1989)

<sup>73</sup> Remenyi, *ibid.*, 170

<sup>74</sup> Yin, R.K. Case Study Research (1984) Design and Methods, Vol.5. Applied Social Research Methods, ed. Leonard Bickman. Beverly Hills, CA: Sage.

<sup>75</sup> Robert E. Stake. 1995. The Art of Case Study Research. Sage: reproduced through arrangements with CANCOPY.



findings.<sup>76</sup> These multiple sources of information were triangulated to support the main assertions of the case study in the concluding chapter.

The theoretical concept of governance, specifically First Nation governance, and emerging themes were developed through the literature review. The research tracked bibliographies, references at the end of journals, conference reports, government documents, computer searches using the University of Manitoba Bison keyword search, Saskatchewan Indian Federated Indian College Search, Royal Commission of Aboriginal Peoples, Health Canada (FNIHB), Department of Indian and Northern Affairs Canada via Adobe, Medline at the University of Alberta, and Spires database at the Canadian Circumpolar Institute at the University of Alberta. The materials gathered focused on keywords, using Aboriginal, First Nation, Indian interchangeably, on topics such as aboriginal governance and administration, aboriginal health and community development, aboriginal administration and the community, First Nations Community Health and administration, aboriginal and health administration, aboriginal management in health services, aboriginal self government and administration, First Nations and participation in health care.

The historical and external sources included public government documents. These helped to describe the larger government policy environment in relation to First Nation Health Transfers and the changes that led to the PBCN Health Transfer. The political and policy history relating to the provision of medical services to First Nations in Canada was particularly significant. Scholars such as T. Kue Young (1988), Frank Cassidy (1991), D. Young and Smith (1992), Robert Depew (1994), Pran Manga, Laurel Lemchuk-Favel

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<sup>76</sup> Cynthia Chataway, *Understanding Strong Indigenous Communities: Research methodology*, from website: <http://www.psych.yorku.ca/chataway/usic/methodology.html>

(1993), Elias (1993), Assembly of First Nations (1996), B. Cohen (1994), S. Culhane (1989), B. Shestowsky (1993), L. Mallock (1989), Noel Dyck (1991), J.E.F. Hastings, W. Mosley (1996), A. Gibbons and Associates (1992), along with a variety of Health Canada publications and journals, provided a good historical policy context for the case study.

The internal perspective was taken from the unpublished internal PB Health documents, reports, Board meetings, conferences, evaluations, and other materials. These PB documents provided the base research data for the PB case study. My own journals and observations as a former employee of PBCN Health during the period studied were not used except for helping provide a contextual history and a reminder when reviewing the research material. I was privileged to access internal administrative and policy documents from PBCN Health, which provided the organizational perspective as to how they set up their organizational and administrative system. Pertinent documents included the 1991 Community Needs Assessment report, the Community Health Plan, the Directional Plan, the Administration and Personnel manuals, the annual reports from 1995-2000, the Board minutes for that term, the first year evaluation, the mid transfer conference proceedings, and other relevant internal reports. Specific community program plans included community development, nursing, home care, holistic health, capital, and family services.

The external perspective came from various pre-transfer and post-transfer community surveys, consultant reports and program reviews, annual conferences. For example, the post-transfer evaluation report by the research unit of Family Medicine at the University of Saskatchewan provided a useful reflection of community opinion about the programs and services being offered by PBCN Health and the use of these services.

With respect to personal ethics, I protected confidentiality, by not identifying the people involved in any situations discussed; neither did I gather direct quotes. The research is strictly limited to literature reviews of both internal and external source documents and no surveys were conducted in that regard. Since I am focusing on governance and the experiences of PBCN Health in that broad perspective, I did not discuss individuals, or personalities; rather I looked at policies, decision-making processes, and operational procedures of the Board as a group. Discussions and examples were limited to Board motions to illustrate Board decision-making. The Board motion allowed me permission to conduct the case study and it covered access to all their internal and external documents.

The PBCN Health Board motion approved this process for my data collection which allowed me access to the organization's documents and while I do acknowledge the advantages of my background knowledge or "preunderstanding"<sup>77</sup> of the organization's development, I was very aware and mindful to base most of my analysis on public documents and not my work journals. I was aware that there were risks in potentially trying to fit the data into my own subjective ideas or into the preconceived elements of western governance theory,<sup>78</sup> but I think that the triangulation of data from the public sources apart from my own provided the validation needed for objectivity and the Board motion permitting me access to all relevant data for my thesis, provided me with the ethical approval from the organization being studied.

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<sup>77</sup> Cynthia Chataway, *Understanding Strong Indigenous Communities: Research Methodology*, from website: <http://www.psych.yorku.ca/chataway/usic/methodology.html>, 122, preunderstanding refers to people's knowledge, experience, insights prior to conducting research.

<sup>78</sup> Linda Tuhiwai Smith, *Decolonizing Methodologies: Research and Indigenous Peoples*, London & New York: Zed Books Ltd., Dunedin, New Zealand: University of Otago Press, 2002, in "decolonizing" research methodologies by promoting indigenous world views



## DEFINITIONS OF TERMS AND ACRONYMS USED

*Bands* - A "body of Indians" of status Indian origin who are recognized in Law (Indian Act) as being under federal jurisdiction and for "whose use and benefit in common, lands, the legal title to which is vested in Her Majesty, have been set apart."<sup>79</sup>

*First Nations* - refers to groups of status Indian origin or registered as Indians under the Indian Act.<sup>80</sup>

*MSB*- refers to the Medical Services Branch of Health Canada who is responsible for the transfer of Indian Health Services to Indian control. MSB has now been changed to First Nations and Inuit Health Branch (FNIHB), but for this case study, MSB will be used.<sup>81</sup>

*PBCN*- The Peter Ballantyne Cree Nation is a First Nation Band in northern Saskatchewan whose population of over 7300 members reside in the eight reserve communities of Pelican Narrows, Deschambault, Southend, Kinoosao, Sandy Bay, Denare Beach, Sturgeon Landing and Prince Albert. Members also live in various city centers like La Ronge, Creighton and Saskatoon.

*PB Health* - refers to *PBCN Health Services Inc.* - the non-profit health organization mandated by the Band to perform all terms and requirements of the Health Transfer Agreement in respect of delivery, administration, provision and control of health services.<sup>82</sup>

*PB Health Board or PB Board or Board* - refers to the Board of Directors of PBCN Health Services Inc.

*PBCN Health Transfer Agreement*- a tripartite Transfer Agreement of health services and programs from MSB to PBCN and PBCN Health Services Inc. for a five year period, April 1, 1995 to March 31, 2000.

*PBCN Transfer Communities*- refers to the four reserve communities under the PBCN Health Transfer Agreement, namely, Pelican Narrows, Deschambault, Southend and Sturgeon Landing.

Although PBCN is made up of 7 northern reserve communities, only four were under health transfer. The rest were still in various stages of getting reserve status under the Federal Treaty Land Entitlement Framework Agreement. For this case study, only the four reserve communities identified in the Health Transfer Agreement are examined.

<sup>79</sup> Lithman Yngve Georg, *The Community Apart: A Case of a Canadian Indian Reserve Community*, Winnipeg, Manitoba: University of Manitoba Press, 1984, 3

<sup>80</sup> Wotherspoon Terry, Vic Satzewich, *First Nations: Race, Class and Gender Relations*, Scarborough, Ontario: Nelson, Canada, 1993, p.xv

<sup>81</sup> Health Canada, *Ten Years of Transfer*, et al. 1999, 3

<sup>82</sup> Health Canada, *The PBCN Health Transfer Agreement*, 1995

## **CHAPTER TWO**

### **LITERATURE REVIEW ON GOVERNANCE: GENERAL & ABORIGINAL**

#### **Introduction**

Governance is a broad and flexible concept in political science generally concerned with the steering functions of organizations and societies. It can be applied to the study of any form and scope of collective action, but rather than just looking at organizational structures and management practices, it is more concerned about the processes involved in making decisions about which directions the state or organization should go. It provides a useful approach for describing the topic of this thesis, which is about a First Nations non-profit organization, PBCN<sup>1</sup> Health Services and the work of its Board of directors and the processes they used in making decisions and policies.

This chapter reviews the concept of governance from the broader political science literature and how it has been used to explain changes to society-state relations in Canada as well as Aboriginal-state relations. While there were many issues raised in the literature, the four main themes that emerged were power and authority, relationships, accountability and political culture. These themes were considered reasonably flexible enough to form a holistic and objective framework for describing the PB Health situation. The concept of governance provided a way for dealing with issues that were not always tangible or measurable, but which nevertheless influenced the decisions and actions taken by the PB Board.

Governance generally tries to explain changes to society-state relations and in this case, the changes caused by the devolution of government programs and services

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<sup>1</sup> The Peter Ballantyne Cree Nation

to non-government organizations were of particular significance since PB Health was created as a result of the federal Indian Health Transfer Policy. The Transfer changed the way health services were being delivered from a government administration to a non-profit Band organization and it subsequently changed the roles and responsibilities of both MSB and the Chief and Council. This was consistent with the discussions in governance literature that suggested that government policies devolving the administration of public services to private or public authorities were changing the roles of both state and society. State scholars were concerned about the potential decline or "withering away" of the power and capacity of central governments to protect the collective interest as a result of their growing reliance upon societal actors to deliver public services.<sup>2</sup> Society scholars interpreted devolution as an alternative to state control where specific powers and authority could be decentralized to social organizations or civil society as a way of enhancing citizen participation in government decision-making, and a way of making society more self-steering.<sup>3</sup> Some scholars took an integrated or blended view where devolution was seen as a positive adaptation by the state to changing political and economic environments and rather than being concerned with adding or limiting government powers, devolution was seen as mutually beneficial.<sup>4</sup>

This thesis favors the integrated state-society version that advocates that society and First Nations in particular, have the capacity to identify their own needs

<sup>2</sup> Turner Mark, David Hulme. Governance, Administration and Development: Making the State Work. West Hartford, Connecticut: Kumarian Press, 1997; also, Skocpol Theda, Kenneth Finegold. "Making the State Work." Political Science Quarterly Vol.97. No.2 (Summer 1982)

<sup>3</sup> Paquet Gilles, David M. Hayne. Governance in the 21<sup>st</sup> Century: Transactions of the Royal Society of Canada Series VI Vol X. Toronto: University of Toronto Press, 2000.

<sup>4</sup> Pierre Jon. Debating Governance: Authority, Steering and Democracy. New York: Oxford University Press Inc., 2000



and to govern themselves more autonomously within the boundaries of the Canadian State. It also acknowledges the continuing significance and interconnection between the state and society in the management and delivery of public programs and suggests that both will mutually benefit because devolution requires negotiated governance where they have to work out social arrangements to balance their interests. It views Health Transfers as a way for the federal government to respond to First Nations concerns for more control over community programs and services without compromising their central authority. In the absence of more sustainable self-government agreements, devolution avoids dealing with the larger Treaty and sovereignty issues around health by allowing limited administrative control over health services and it also provides a way for the federal government to have First Nations become more involved in addressing the immediate health problems in their communities.

While Transfers are essentially administrative mechanisms within what some might call colonial frameworks, First Nations generally view them as transitional steps in preparation of self-government. Transfer arrangements such as the PBCN Health Transfer Agreement have provided PBCN communities with more opportunities to administer and manage their own programs and services. The overt control by the federal government as described in the later chapter on the history of federal Indian Health policies has changed with First Nations asserting and taking more control over their own affairs through various forms of political and social organizations. The fact there is now a plethora of services such as schools, health clinics, child and family service agencies being operated by various local committees,

boards, and Band administrations, demonstrates growth in local community development but what has been unclear is the nature of these developments. In trying to help fill this gap, this thesis provides the example of the governing experiences of the PB Health Board during their first five years of managing the PBCN Health Transfer Agreement.

### **Building the Thesis Framework**

According to scholars such as Tim Plumptre and John Graham from the Institute on Governance, governance is generally about an entity "steering" or making decisions about directions, and hypothetically could be applied to any variety of collective action.<sup>5</sup> It concerns itself with the more strategic aspects of steering or the larger decisions and roles rather than the day-to-day management type of issues. While governance is more commonly discussed in relation to the actions of states (countries) in global or national arenas, it has also been used in corporate governance to describe the activities of profit and non-profit organizations and their governing board of directors. The issues of corporate governance therefore tend to concentrate on the role of the board of directors, their relationships to executive management and their accountability to shareholders.

While management studies focus mostly on organizational rules and order and the behavior of management and staff, governance studies take a broader perspective examining decision processes and relationships between the governing and the governed or rather in this case, between those governing PB Health services (the Board) and everyone else. The issue of governing is an interesting concept. It

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<sup>5</sup> Plumptre Tim, John Graham, Governance and Good Governance: International and Aboriginal Perspectives, Ottawa: Institute on Governance, December 1, 1999, 3

suggests tangibility in the sense of assuming that those in authority are the ones in power, but this is not always so clear. Decision-makers do not live in islands of neutrality but are always influenced in one way or another by external factors and relationships. Decision-making is also not as clear as it sounds. There are many layers and functions of decision-making in most organizations, both official and non-official, ranging from those who create policies, to those that implement them, and to those that receive them. In this case, for brevity's sake, the focus is on the PB Health Board in relation to other key players in the PB Health Agreement and more specifically upon their official functions and experiences as policy-makers and primary decision-makers for the health organization.

What do decision-makers normally do? In the case of boards and organizations, the general understanding is that boards of directors make policies and major decisions. What are public policies? According to broad definitions, most scholars agree that public policies result from decisions made by governments. Howlett and Ramesh, for example, suggest that "public policy is, at its most simple, a choice made by government to undertake some course of action."<sup>6</sup> In governance literature, policy-making is considered a fundamental function of governance in terms of its common conceptual representation of coordination or "steering" of social systems.<sup>7</sup> In the case of the PB Board then, determining how they "steered" or made policy decisions will require looking at the methods by which they made their

<sup>6</sup> Howlett Michael, M. Ramesh, Studying Public Policy: Policy Cycles and Policy Subsystems, Toronto: Oxford University Press, 1995, 5

<sup>7</sup> Rhodes R.A.W. in Pierre Jon, ed., Debating Governance: Authority, Steering and Democracy, New York: Oxford University Press Inc., 2000, 57; also, Plumptre Tim, John Graham, Governance and Good Governance: International and Aboriginal Perspectives, Ottawa: Institute on Governance, December 1, 1999, 3



decisions, which in this case was largely through their Board meetings where corporate decisions were made, policies approved, and directions given to managers to implement. Describing corporate decisions and management directions regarding larger operational issues such as choosing banks or signing agreements is fairly self-explanatory. However, policy-making functions are not as easy to describe because they are less tangible and involve more people and processes other than the Board.

Most public policy approaches are concerned with participation issues in the state-society relationship between central governments and individuals, civil groups and institutions. Howlett and Ramesh provide a useful summary of the more common approaches.<sup>8</sup> For example, Welfare Economics and Public Choice approaches believe that individuals in the market systems can best shape good public policy and they therefore tend to favor less government, but in the case of market failures, political institutions are expected to intervene and make social decisions supporting the market systems. Critics argue that these individualist approaches fail to appreciate that state governments and individuals almost never make policies as technically or as rationally as depicted because they are influenced by political pressures. In this case, the focus on economic and utilitarian ends was too narrow to be applied to the Board situation because PB Health was a public service, non-profit organization dependent on government funding, rather than the more economically independent, for-profit businesses to which the Welfare Economics and Public Choice approaches refer.

Pluralism and Corporatism approaches, on the other hand, favor groups rather than individuals believing that interest groups in society are the key shapers of public

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<sup>8</sup> Howlett Michael, M. Ramesh, Studying Public Policy: Policy Cycles and Policy Subsystems, Toronto: Oxford University Press, 1995, 50-52

policy. Among the overlapping memberships of these groups, public policies are seen as products of the competition and cooperation among groups striving to maximize their collective interests. These societal approaches are often favored because they recognize the influence that citizen and other non-government groups and agencies have with governments. For instance, Tim Plumptre, John Graham, Gilles Paquet, David M. Hayne, Miriam Wood, Frank Cassidy, Robert L. Bish, Peter D. Elias and others promoted the idea of studying varieties of participatory and community empowerment models of organization such as non-profit agencies<sup>9</sup> and consociational (consortiums) institutions<sup>10</sup> and aggregate networks,<sup>11</sup> all of which were largely premised on the idea of governments devolving certain functions to society groups who in turn would create democratic organizations for the purposes of carrying out these public services. Critics to these group approaches argue that they are too narrowly focused on groups and fail to consider the equally important roles of the state governments and other international social and economic affiliations in shaping public policies. While the Pluralism and Corporatist approaches were more applicable to the PB situation than the economic approaches, they needed to be

<sup>9</sup> Plumptre Tim, John Graham, Governance and Good Governance: International and Aboriginal Perspectives, Ottawa: Institute on Governance, December 1, 1999, 6, describes the importance of 'civil society' as referring to civic associations organized by citizens for social and political purposes—in essence voluntary and non-profit organizations. Also, Paquet Gilles, David M. Hayne, Governance in the 21<sup>st</sup> Century: Transactions of the Royal Society of Canada Series VI Vol X, Toronto: University of Toronto Press, 2000; Wood, Miriam M. (ed.), NonProfit Boards and Leadership: Cases on Governance, Change, and Board-Staff Dynamics, San Francisco: Jossey-Bass Publishers, 1996; Cassidy Frank, Robert L. Bish, Indian Government: Its Meaning in Practice, Lantzville, B.C.: Oolichan Books and the Institute for Research on Public Policy, 1989. Elias Peter Douglas, Development of Aboriginal People's Communities, North York, Ontario: Captus Press Inc., 1991

<sup>10</sup> Hirst Paul in Pierre Jon, ed., Debating Governance: Authority, Steering and Democracy, New York: Oxford University Press Inc., 2000, 14–24, talks about consortiums of self-governing institutions resolving problems through negotiated governance as potential models for sustainable governance.

<sup>11</sup> Kooiman Jan in Pierre Jon, ibid., 134, refers to Aggregation in terms of levels of socio-political interactions in societal governance; and the Institute on Governance, Aggregation Among First Nations: A Handbook For Self-Government Negotiators, Ottawa: Institute on Governance, June 2001, 2 refers to Aggregation (collaboration) in terms of various governance models for self-government.

broadened here to recognize the close relations that the Board had with the PB Chief and Council and MSB under the Transfer and their influence in shaping policy.

The other more common approach was the state approach, but like the others, it by itself was also too narrow to be used here, and although the governments (Chief & Council, MSB) were instrumental in the establishment of the PB organization, and worked closely with the Board after they formed, they did not mold the PB Health policies. State theorists favor the state government as the leading institution in society for shaping public policy. The assumption is that rather than just responding to political pressures from the market or groups, states have the power to carry out their own objectives. According to Howlett and Ramesh, some of the leading state theorists such as Max Weber and Theda Skocpol, were not so concerned about the representative nature of state government, but rather on how the state used its sovereignty to govern and structure social relations and institutions. Some criticisms of statist approaches suggest they are too narrow in that they fail to consider that governments cannot always force their will on society, as in the case of revolutions for example, and that democracies with their voting rights, can never really be autonomous from the public will.

Some of the broader versions of state approaches range from those focusing on other forms of social organizations or political institutions to ones focusing on the linkages and relationships between state structures and society. David Easton, for example, viewed the relationships between government and society in terms of systems of inputs and outputs to show how the stimuli from the external environment was inputted into the government system, churned around and pushed out in the form



of policies (decisions and actions) with the cycles repeating over and over creating changes in response to changing environments.<sup>12</sup> However, Easton's depiction of the political system was also prone to criticisms for being too narrow and artificially portraying government policy-making and policy-makers as being neutral and separate when in fact they were not and things were not always so clear-cut. In other words, state-society relationships could not be contained and explained properly within conceptual boxes because they were too unpredictable and subject to too many environmental influences.

In spite of the limitations of these various approaches towards decision-making in minimizing either state (structure) or society (group) factors, most agree that both are prone to many internal and external environmental influences, and in democratic societies, no one group or government entity can govern autonomously by themselves. It is also evident that the role of the state and the public sector is changing towards a more participatory policy agenda<sup>13</sup> with the governments promoting more public participation in decision-making through various devolution strategies, such as the PB Health Transfer. While some imply that the state is withering away with devolution, others would argue that at its worst, devolution is creating different forms of shared governance between the government and society (non-government agencies). Jon Pierre, for example, sees devolution as the state's way of adapting, not declining, to changes in its external environment. Its functions

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<sup>12</sup> Brooks Stephen, *Public Policy in Canada*, Toronto: McClelland & Stewart, 1989, 44, 45

<sup>13</sup> Paquet Gilles (organizer), David M. Hume (ed.), *Governance in the 21<sup>st</sup> Century: Transactions of the Royal Society of Canada, Series VI, Volume X*, 1999, Toronto: University of Toronto Press, 2000, discuss the 'activist' theme that arose out of perceived governance failures in Canada to deal with social problems.

are changing from direct control to coordination in this new, shared governance arena.<sup>14</sup>

### TRENDS IN BROADER GOVERNANCE LITERATURE

In general, political science governance literature has been preoccupied at the global level with the growing incapacity of states and their institutions both in industrialized and developing countries to resolve domestic economic and social problems caused by internal and external pressures. Globalization, for example, is a popular idea in political science concerned with how countries are being affected by world trends and governments are responding to them. It refers to the increasing integration of "worldwide processes of increased technological, trade, financial, and informational flows that penetrate countries and affect domestic society."<sup>15</sup> The influence of multinational corporations and open trade rules are several examples of pressures caused by a global economy.<sup>16</sup> The trend in general governance literature has been towards an institutional focus with political science, for example, dealing with the changing role of the state government and its institutions<sup>17</sup> and public administration dealing with various management and bureaucracy paradigms in its quest for efficient government administration.<sup>18</sup>

A scan on governance literature has shown that the concept has been applied as an explanatory framework for the failure or at least diminished capacity of the state

<sup>14</sup> Pierre Jon, ed., Debating Governance: Authority, Steering and Democracy, New York: Oxford University Press Inc., 2000

<sup>15</sup> Hughes Barry B., Continuity and Change in World Politics: Competing Perspectives, Fourth Edition, Upper Saddle River, New Jersey: Prentice-Hall Inc., 2000, 431

<sup>16</sup> Jackson Robert J., Doreen Jackson, Politics in Canada: Culture, Institutions, Behaviour and Public Policy, Sixth Edition, Toronto: Pearson Education Canada Inc., 2006

<sup>17</sup> Easton, David (1965), Theda Skocpol and Kenneth Finegold (1982), Leo Panitch, Ted Schrecker (1984),

<sup>18</sup> Gerth and Mills on Max Weber (1946), Peter F. Drucker (1995), Andrew Dubrin (1997), Kernaghan Kenneth (1968)

to "steer" society in the "old" way as some scholars would say, where the state had the monopoly of the political and administrative authority over the delivery of public services. Governance is used as a blanket term to explain the changes in the distribution of political and administrative power from the central state government to the private, municipal and non-government sectors of society. This is where the role or function of the state and the role or function of non-state actors in public policy and public administration in a democratic state become a foundational question in governance.

Some state capacity scholars view this transfer of political and administrative power to the other societal actors as a "decline of the state."<sup>19</sup> Others see it as an indication of the state's capacity to "adapt" to the pressures of its environment. In their view, public participation strategies in public governance supplement rather than threaten the traditional role of the state government as a sovereign power in a democratic state. Most policy theorists agree the state is no longer a unitary actor.

<sup>20</sup> Many blame world market forces on domestic politics as being the impetus to force some states to centralize and some to decentralize, both of which influence the sovereign power of the state and its various manifestations.

The literature demonstrates that a change or transformation has occurred in state-society relations where the state has delegated some of its steering powers to other stakeholders in society, particularly in the areas of public policy and delivery of

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<sup>19</sup> Skocpol Theda, Kenneth Finegold. "Making the State Work." Political Science Quarterly Vol.97. No.2 (Summer 1982); Turner Mark, David Hulme. Governance, Administration and Development: Making the State Work, West Hartford, Connecticut: Kumarian Press, 1997

<sup>20</sup> Paquet Gilles, David M. Hayne, in David M. Hayne, ed., Governance in the 21<sup>st</sup> Century et.al, 2000; also, Pierre Jon, ed., Debating Governance. et.al, 2000



public services. The shift has been described in terms of government to governance<sup>21</sup>, public sector to public/private sector,<sup>22</sup> old and new,<sup>23</sup> centralization to decentralization,<sup>24</sup> transformation, new and emerging,<sup>25</sup> more state to less state to declining/adapting state, centripetal to centrifugal, monopoly power to coordinator of larger objectives,<sup>26</sup> all of which reflect changing roles in both state and society functions.

The perspectives vary from state-centric to society-centered to blended integrated analyses. State-centric or centripetal analysis is more consistent with the "old" perspectives that concern themselves with state capacity and keeping the state strong. Theda Skocpol, Jon Pierre, Mark Turner, David Hulme, Judith Gruber, Cairns and others, suggest that examining the structure of the state and its public sector institutions will explain the reasons why the state is losing political legitimacy and influence. Society-centered analysts, on the other hand, concern themselves with society-capacity that is more like the 'new' centrifugal perspectives that focus on how social agencies are structured. Tim Plumptre, John Graham, Gilles Paquet, David M. Hayne, Miriam Wood, Cassidy and Bish, Peter D. Elias and others examine various vehicles of public participation and community development in governing through non-government agencies, consociational institutions<sup>27</sup> and aggregate networks.<sup>28</sup>

<sup>21</sup> Plumptre Tim, John Graham, Governance and Good Governance: International and Aboriginal Perspectives, Ottawa: Institute on Governance, December 3, 1999

<sup>22</sup> Turner Mark, David Hulme, Governance, Administration and Development: Making the State Work, West Hartford, Connecticut: Kumarian Press Inc., 1997

<sup>23</sup> Peters Guy in Jon Pierre's Debating Governance, et.al, 2000

<sup>24</sup> Paquet Gilles, David M. Hayne, in David M. Hayne, ed., Governance in the 21<sup>st</sup> Century et.al, 2000, introduce distributed governance resulting from decentralization

<sup>25</sup> Cairns, Alan C., in Governance in the 21<sup>st</sup> Century et.al, 2000

<sup>26</sup> Pierre Jon, ed., Debating Governance, et.al, 2000

<sup>27</sup> Hirst Paul in Jon Pierre, ed., Debating Governance, et.al., 2000, talks about the consortium of associations concept as providing a stable institutional base for effective governance

Some imply that the state is withering away but most accede to the notion of the state-society exchange as a shared or distributed governance. The integrated perspective combines both approaches portraying the state as going through a period of transformation, not decline and shifting from direct control to a more coordinating role through devolution in the new shared-governance arena. Scholars like Robert Depew, Jon Pierre, Cairns, Plumptre, and Graham suggest that the state is becoming less overtly intrusive in public affairs through devolution, but it is still the central political power.

Jon Pierre (2000), Mark Turner, David Hulme (1997), Gilles Paquet (2000), Miriam M. Wood (1996), the Organization For Economic Cooperation and Development (1995, 2001) and others have focused their work on the changing role of the state with a positive spin towards the capacity of the state to adapt to these political and economic pressures through a variety of adaptation strategies such as the decentralization and devolution of programs and services to non-governmental organizations.

Turner and Hulme were concerned with the ways the public sector was operating in developing countries, as well as in the industrialized countries where in the 1990s, the policy trend was to minimize the role of the public sector in response to the 'rolling back the state' ideology that had become popularly associated with 'good government.' They argued that the public sector still had an important role to play in development, that both the state and the market should be integrated. The

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<sup>28</sup> Kooiman Jan in Jon Pierre, *ibid.* 2000 and the Institute on Governance (2000) both refer to levels of aggregation in socio-political interaction with distinctions between first, second, third level governing. First being direct level, second being supervision, coordination, and third being the specialized, enforcing accountability upon the governors.

question for them was "how could the private-public sectors collaborate to better meet social needs?"<sup>29</sup> Similarly, E.H. Fry, (1998)<sup>30</sup> was concerned with the less state-more private/public trend in US foreign policy with the growing influence of competing subnational (cities, regions) governments in the international arena leading to an erosion of state power. Marsh and Rhodes raised similar concerns with competition leading to the erosion of traditional state powers by policy networks.<sup>31</sup>

Gilles Paquet, and David M. Hayne,<sup>32</sup> in a symposium on governance by the Royal Society of Canada in 1999, discussed the 'activist' theme that arose out of perceived 'governance failures' in Canada, to deal with national problems in many spheres like health, education, economy and the environment. They argue for a more 'distributed governance,' in all sectors through the decentralization or noncentralisation of power, where organizations become more horizontal in structure and managers become team leaders with a focus on coordinating teams and networks. For them, distributed governance is 'good' governance and it is characterized by a situation where other stakeholders have capacity to influence the process of governance, and state institutions do not have monopoly over it, and the way to steer is done through collaboration and cooperation.

Paquet states that studying governance at any level means examining the distribution of rights, obligations and powers of organizations and their networks, their coordination systems, their dysfunctions and restructuring strategies. It is more

<sup>29</sup> Turner Mark, David Hulme, Governance, Administration and Development: Making the State Work, West Hartford, Connecticut: Kumarian Press, 1997, xii

<sup>30</sup> Fry, E.H., The Expanding role of State and Local Governments in US Foreign Policy Affairs, New York: Council on Foreign Relations Press, 1998

<sup>31</sup> Marsh, D., Rhodes, R.A.W. (eds.) Policy Networks in British Government, Oxford: Clarendon Press, 1992

<sup>32</sup> Paquet Gilles (organize), David M.Hayne (ed.), Governance in the 21<sup>st</sup> Century: Transactions of the Royal Society of Canada, Series VI, Volume X, 1999, Toronto: University of Toronto Press, 2000



than the preoccupation with government's capacity to steer, beyond the public sector (Gruber), it has to do with a complex socio-economic system and its coordination through decentralization. For organizations, the prescription is clearly away from the Weberian model of centralized control and hierarchical bureaucracies to one where power is horizontally dispersed throughout the organization among teams being led by leader-managers skilled in motivation and coordination. Deliberation and negotiations through partnerships at the local level become the guiding processes and enforcement of these decisions would be through moral social contracts and reciprocal obligations. This version of 'distributed governance' seems to be a political version of the invisible hand that would guide the partnerships, but for others, who are wary of state decline, the invisible hand would be quite visibly that of the state and its institutions, albeit in more of a coordinating role as opposed to top down rule.

Jon Pierre argues that the emergence of governance in the 1990s speaks to the state's ability to adapt, not decline, to changes in its external environment through various institutional responses, such as national deregulation, privatization, restructuring the civil service, imposing 'managerialism' in the public sector, and devolving governing function to semi-autonomous organizations.<sup>33</sup> While he acknowledges that the state is becoming less overtly obtrusive in public affairs, he argues that it is still the vehicle of collective societal interest and therefore, its role in governance studies remains integral. How it transforms to accommodate the emerging forms of governance becomes the key question for him. He suggests that the state is being transformed rather than being in a state of decline as a result of devolution.

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<sup>33</sup> Pierre Jon, (ed.), *Debating Governance: Authority, Steering and Democracy*, New York: Oxford University Press Inc., 2000

Jon Pierre sees a connection between the lessening of the regulatory steering function of the government and the emerging public-private sector exchange as a move from a centripetal to a centrifugal model of governing. In the centripetal model, the state has monopoly power, and in the centrifugal model, the state is more the coordinator of its larger objectives through deregulation and decentralization. Others like Paul Hirst note that this kind of governance makes the state appear nebulous and its role unclear. It raises questions such as 'how is conflict resolved in a governance system made up of autonomous actors brought together to solve a common problem?

Paul Hirst<sup>34</sup> in looking at democracy and governance, also talks about the multiple meanings and ambiguity in the use of governance as a concept. It is generally seen as an alternative to government control and is primarily used in technocratic and elite discourse. In this vein, non-government organizations could now be seen as alternative elites to the traditional government elites. Governance is also used to satisfy the post-political search for effective regulation and accountability and it covers all fields including economic development, international institutions and regimes, corporate governance, growth of new public management strategies, and the negotiated social governance evidenced by new coordinating functions of the state through networks and partnerships. He argues that governance requires a stable institutional base to be effective and negotiated forms of governance through consociational institutions and practices (consortium of associations' concept) could supplement both representative democracy at the national level and associational self-governance at the local level.

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<sup>34</sup> Hirst Paul in "Democracy and Government," in Jon Pierre's Debating Governance, 2000, 14

Guy Peters referred to the main governance approaches in the context of "old" and "new" governance.<sup>35</sup> The old refers to the state monopoly over power and control in society and is consistent with the state-centric models of explanation. The "new governance" refers to what he sees as the fragmented approach to how the state interacts with society to reach consensus decisions and is consistent with the society-centric models of explanation. Both approaches assume society has to be governed but who does the steering becomes the debated issue. Public administration literature and comparative politics dominated by descriptions of behavior in the public sector, its functions and the way it performs, now with the inclusion of public participation in the public sector functions, capacity issues have been raised by proponents like Robert Putnam who see social capital as being integral to good governance.

Jan Kooiman<sup>36</sup> depicts societal governance as consisting of different levels of social, political interaction which are consistent with descriptions of levels of service in public policy. He suggests that these refer to the shifting roles of government as opposed to shrinking roles in these new relationships. First order governing is aimed at solving problems directly at a certain level; second order governing tries to influence the conditions to make it conducive for first order governing; and the third order refers to who or what governs the governors?

The Organization for Economic Cooperation and Development (OECD), the conglomeration of mostly industrialized states that debate global policy, of which Canada is a member, suggests that governance is in transition and this is

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<sup>35</sup> Guy Peters in "Governance and Comparative Politics," in Jon Pierre's *Debating Governance*, 2000, 45

<sup>36</sup> Kooiman Jan in "Societal Governance: Levels, Modes, and Orders of Societal-political Interaction," in Jon Pierre, *ibid*, 154



demonstrated through public management reforms in member countries. It raises issues of how government relates to citizens and business, how to best deliver public services, and how to define the inherent functions that governments must continue to perform. It is primarily concerned with how the state can maintain capacity in the face of great change. Thus for governments facing the 21<sup>st</sup> century, the policy challenge for governance is one of institutional renewal.

Its view is that corporatism and privatization are important principles in making the public sector more business-like. The basic message is to decentralize the public sector and create new paradigms for public service management centered around developing a 'performance-oriented culture'<sup>37</sup> where the focus is on results, devolution of resource allocation and service delivery decisions to local areas, flexible regulatory systems, performance requirements and enhanced accountability in public sector administration, and to provide strategic capacity for the state to guide its development and be able to respond to external changes and complex interests. For the OECD, the focus for governance in the modern 'information age' is to forge new relations between governments and a highly informed and better educated society. Therefore, the principles of greater transparency and participation are fundamental and thus it is preoccupied with developing tools for public sector management rather than the functions of the state.

Development scholars, Mark Turner and David Hulme agree with the general proposition by the OECD that the nature and performance of public sector organizations are critical to developmental success, as demonstrated by the East

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<sup>37</sup> OECD, Governance in Transition: Public Management Reforms in OECD Countries, Paris, France: OECD, 1995, 8

Asian 'tigers' of South Korea, Taiwan, Singapore, Thailand and Malaysia, all with strong public sector organizations. However, they do not concur with the technical fix approach of management systems, procedures and organization designs because they are not value neutral or universally applicable. They argue that political considerations have to be included in the administration analysis and practice, because the interactions occur within political environments, therefore the principles of power and authorities have to be considered.

Their thesis is that development theory should be rejuvenated and is still applicable in spite of the prevailing disillusionment with the results of its explanatory framework. They discuss the growth of development administration as the practical application of modernization theory grounded in rational scientific principles and Keynesian welfare economics. Synonymous with public administration, it promotes the classical school management theories with Taylor's scientific managers, and Weber's ideal type bureaucracies, where culture and 'big' government are seen as impediments to progress. Even though the behavioral management theories largely replaced the classical theories in the 1970s, and the open systems and contingency theories<sup>38</sup> dominated the 1980s, the developing countries still continue to organize their public services along the classical lines. Therefore, for developing countries, 'reinventing government' may not mean reducing the role of the state and its functions to that of a minimalist state.

Clearly the coordinating role of the state in the public sector in Canada is changing towards a more participatory policy agenda that promotes public

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<sup>38</sup> Turner Mark, David Hulme, *Governance, Administration and Development*, et.al., 1997, 15, 'Open systems' sees organizations as systems of interrelated parts which relate to the environment, and 'contingency theories' argued that organizational structures had to fit their environment

participation in decision-making by non-profit organizations engaged in delivering public services. Miriam M. Wood, for example, focuses her work on the leadership, change and management of charitable non-profit organizations. What is useful for me is that she presents case studies as examples of governance theory in action, and unlike the trend of most public administration literature, she focuses on governance as opposed to management. For her, governance is a broader concept dealing with processes as opposed to bureaucratic rules, where decisions and actions are linked to defining the organization's mission, creating policies, identifying the control mechanisms to distribute power, creating decision-making processes, and developing procedures for specific tasks, functions and roles.<sup>39</sup> She agrees that the study of governance has to take into account "other stakeholders" who are potentially affected by decisions made by NGOs and their administrators. She suggests that one way of measuring an organization's accountability is to assess its structures and processes of governance.

Wood describes two theoretical models of non-profit governance in decision-making – the political and the paradoxical. The political or governance-by-stakeholders model suggests that governance has three different functions. First, it provides a consultative framework for stakeholders whose right to participate has been established; Second, the framework provides experiential precedent for conducting negotiations when a new person or group seeks recognition as a party to governance; And third, the ongoing practices of governance help legitimate and institutionalize changes in relationships between the stakeholders. The paradoxical

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<sup>39</sup> Wood, Miriam M. (ed.), NonProfit Boards and Leadership: Cases on Governance, Change, and Board-Staff Dynamics, San Francisco: Jossey-Bass Publishers, 1996, 3



model arises from legal contradictions where the board as a unit has the authority to govern as an organization. Yet, structural tensions arise when the board appoints its chief executive to be in charge of the organization's day-to-day business, but cannot fully control what that CEO does. This is often called the principal-agent problem. The capacity of the board to add value to the organization is also questionable, because of their reliance on administration staff for information and knowledge. As well, strong board members may sway the board away from group to more individualistic orientation.

James Gillies, Peter Drucker and others suggest that the significance of boards had historically been marginalized in both corporate practice and literature. However, since the 1990s, various degrees of what Gillies referred to as "boardroom renaissance" have occurred in organizations and corporations with the boards becoming more active in exercising their legal and political powers to govern. Rather than just "cooperative rubber stamping and window dressing" management decisions, they have become active partakers in setting policy directions and monitoring the performance of their managers in meeting the goals and missions of their organizations.<sup>40</sup> Their role and function as representatives of shareholders or the membership, and their trustee responsibilities for the overall governance of the organizations have increased the level of their political, legal and administrative accountability to both the state and society. These responsibilities have generated

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<sup>40</sup> Gillies James, Boardroom Renaissance: Power, Morality and Performance in the Modern Corporation, Toronto: McGraw-Hill Ryerson Limited, 1992, 8 and Peter Drucker in Charles A. Anderson and Robert N. Anthony, The New Corporate Directors: Insights for Board Members and Executives, New York: John Wiley & Sons, 1986, 1

concerns with adequate board capacity, power, accountability and governance relationships, all of which are relevant in any study of governance.

The question of whether non-profit organizations are the best governing vehicles for representing the public interest in a civil society has elicited strong views in both government and academia, but Wood suggests the answer to this question is not clear in practice. The OECD, for example, is a strong proponent of more public participation and of strengthening government-citizen relations by using information, consultation and active participation strategies in decision and policy-making. The theory is that representative democracy is based on the consent of citizens, not only through the vote, but also through their interaction with governments through organized groups.<sup>41</sup> What Woods does is move away from making similar prescriptive suggestions by using her case studies to portray the political realities that a governing board has to face in practice, such as constraints in structural paradoxes; in its mission, industry and strategic planning; history and culture; organizational form; formal and informal networks; and funding sources. She groups her cases of board leadership into three areas: the role of external stakeholders in governance; complexities in the board-staff relationship in decision making; and interpreting mission and accountability.

Judith E. Gruber takes a more traditional view of governance by framing it around the more formalized state-centric notions of democratic governance and the interactions between the state bureaucracies and the elected representatives of civic society, instead of semi-autonomous agencies. Her focus is on the political and

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<sup>41</sup> OECD, Citizens as Partner: OECD Handbook on Information, Consultation and Public Participation in Policy-Making, Paris, France: OECD, 2001

administrative problems in democratic governance and citizen participation, all of which are targeted to "controlling bureaucracies"<sup>42</sup> through a variety of control strategies. In theory, bureaucracies are supposed to function as administrators and servants of publicly elected officials representing public interests. The problem is that bureaucracies also function in the political realm in the area of public policy-making without being elected. The danger for democratic control is that bureaucracies could act in the name of the public, without being influenced by the public. For her, the idea of constraining the public sector is an essential component to any map leading the way to a democratically controlled bureaucracy.

Like Wood, she suggests that reality is not easily compartmentalized into neat political and administrative areas as suggested by the traditional Weberian theory of administration. The notion of the neutral bureaucrat working with equal diligence for all political masters is illusory. The notion of separating the administrative functions of the bureaucrat from the political or policy-making functions of legislators and elected officials is not reality. Democratic control maintained by the accountability of bureaucrats to the elected officials is hard to enforce. In reality, both politicians and bureaucrats have strong influence in making public policy and decision-making.

Reality, therefore, requires constraints upon the functions of the bureaucracy. While she recognizes that there are other constraining variables within organizations such as formal procedural controls and resource capacity issues, her emphasis is focused on democratic control which she feels can only be done through the actions

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<sup>42</sup> Gruber Judith, E., Controlling Bureaucracies: Dilemmas in Democratic Governance, Berkeley and Los Angeles, California: University of California Press, 1988



of political actors such as citizens acting alone or in groups or their elected officials. She provides a useful framework for assessing approaches to democratic control which basically identify the behaviors needing to be constrained as procedures used to make decisions (the how) and the substance of the decisions actually made (the what). All decisions have both the procedural and substantive aspect, and either or both can be constrained through specific control mechanisms as identified in the more popular approaches to democratic control. These include controls through participation, clientele relations, pursuit of the public interest, accountability and self-control - all are traceable to the citizenry, for "without the hand of the citizen, democratic control of bureaucracy does not take place."<sup>43</sup> She also examines the problem of democratic control from the perspective of the bureaucrat and the differences among the policy areas where control takes place.

Gruber's thesis tries to change the focus of the traditional ideas of control as based on authority relationships to one that sees control based on a model of exchange, which could also be seen as forms of political coercion, or what Hecllo called 'conditional cooperation' as opposed to 'invoking authority'.<sup>44</sup> In the control by exchange model, politicians create conditions that constrain bureaucratic behavior through the process of exchanging resources needed on both sides. For example, institutional arrangements that distribute or "fragment" power and resources could create conditions of mutual dependency and interaction between the politicians and the bureaucrats.

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<sup>43</sup> Gruber Judith, E., *Controlling Bureaucracies*, *ibid*, 1988, 13

<sup>44</sup> *ibid*, 214

The problem with Gruber's thesis is that the analysis limits constraints to the bureaucracy. As part and parcel of the government, the public sector or bureaucracy as well as the elected officials are both to be constrained, with the power and resources being distributed and devolved to non-profit agencies, whose boards are made up of citizens and not politicians. What is useful, however, is that she raises fundamental issues of democratic control by elected politicians who constitutionally represent the interests of society and she provides a useful framework describing the various approaches taken in public administration and policy literature to limit bureaucratic control in government decision-making.

What all these various perspectives on governance suggest is that governments are being forced to change their customary ways of governance as a result of influences both internal and external to their countries. The government monopoly over public services has failed to resolve the growing problems in crucial areas like employment and healthcare and faced with mounting public discontentment, governments are consequently exploring policy alternatives towards more distributed governance with the private and non-government sectors through various devolution mechanisms. This decentralization or transfer of certain powers and services is changing the role of government to more of a monitoring and support role in public administration. The PB Health Transfer is one example. With this trend away from government control to more community control comes the need to try to understand the new forms of governance and the new relationships with the government (state) and the public being served. In this case, the analysis on PB Health is more reflective of societal scholars such as Paul Hirst, Jan Kooiman, John

Pierre and others who concern themselves with the structures and capacities of social agencies and non-government organizations rather than the state scholars who focus on government systems and capacities. While the broader debates raise issues of whether the state through devolution is in fact causing its own decline and compromising its role as a central authority or whether its just adapting or even transforming itself to accommodate the changes in society to ensure its survival, the reality is that governance is changing and needs to be better understood.

The literature also helped to identify issues commonly found in governance, which helped to develop the themes of this case under the broad framework of power, relations, accountability and political culture. Paul Hirst, for example, raised power relations and accountability issues in the discussions around capacity building and the need to develop sustainable institutional structures in order to more effectively implement policies and decisions. Society scholars such as Tim Plumptre, John Graham, Miriam Wood and others advocate the benefits of devolving government programs and services to non-government agencies, most of which raise power and relational issues. Some of the benefits discussed include greater potential for negotiated governance, better distribution of power, more public participation and community development. The changes imply less control and more coordination by the State and central government institutions. The inference is that devolution will lead to more collaboration less competition between the state and private and/or civil society, but for this to occur relationships and networks have to be redefined and the distribution of rights, responsibilities, accountability and powers better defined. The preferred models of public governance seem to be those based on a blend of



behavioral and corporate management principles characterized by a more decentralized bureaucracy, teamwork, less hierarchy or top down command structure and a more horizontal dispersion of power, with the managers leading by inspiration and example rather than force and control, and the enforcement of accountability through various kinds of negotiated moral contracts and agreements.

There are the other views of course, which are more cautious with respect to advocating the merits of governance as an analytical tool, and the associated benefits of devolution and public governance through non-profit organizations. Paul Hirst, for example, speaks about the ambiguity and multiple meanings of governance and how governance could be seen as an alternative to government control and manipulated in technocratic and elite discourse. Non-government agencies could be perceived as alternative elites to traditional government elites. Governance could also be used to satisfy the government's quest for effective regulation and accountability covering all areas such as corporate governance, economic development, negotiated social governance through partnerships and networks. A similar debate carries on in First Nation health transfers. Some perceive health transfers as a means of community empowerment and a step towards self-government and others see it as an offloading of federal responsibility to First Nations, especially with the capped or envelope funding formulas. Nonetheless, the reality is that more First Nations are taking over their own administration of government services thus raising similar issues of legitimacy and accountability in First Nation communities in relation to Band governments.

In the case of PB Health for example, the corporate model is an evolved form of Band governance where Community-based representatives from the general public rather than Chief and Council make up the Board. As far as political power is concerned, the community is represented on the organizational structure in the form of Chief and Council. What is interesting to note is that it is generally assumed that First Nations will develop less bureaucratic systems given their negative experiences with highly bureaucratized institutions such as Indian Affairs, and their communal oriented cultural history, but if First Nation experiences could be compared to the experiences of developing countries who generally continue to organize their public services along classical bureaucratic lines, then it could also be equally assumed that First Nations will do likewise. That comparative leap, however, cannot be made here because this is just a single case study, but given the rather formal bureaucratized nature of PB Health's organizational development, it does have some bearing, although there was also a concerted effort by the Board to keep the central management bureaucracy small in favor of targeting more resources to local employment and training.

The case study acknowledges that the concept of governance is rather ambiguous, but it has its merits as an analytical framework because it considers the context of whatever the focus of the study is. It acknowledges the growing significance and roles of new governing authorities such as boards, rather than just narrowly focusing on government systems and management systems. Governance also raises good governance and effective management issues by debating between the risks and benefits of developing classical bureaucratic styles of organizational

development versus the behavioral management theories promoting flat organization structures, teamwork and consensual leadership. In the PB case, for example, the concept allows for a framework that focuses on Board governance and decision-making rather than inadvertently limiting the value and significance of a Board of Directors in organizational development in favor of a debate about the merits or demerits of management systems. This does not imply that PB Health management is insignificant, but the framework raises the focus away from profiling individual efforts to profiling communal efforts, which is what the concept of governance is based upon. This follows the general idea promoted by Miriam Wood who uses case studies as examples of governance in action focusing on leadership and change of non-profit organizations rather than just narrowly examining their management systems. She also raises issues of relationships between the Board and administration, which is certainly vital to understanding Board decision-making.

Jan Kooiman's references to different levels of interaction in societal governance are useful in recognizing that there are various levels to governance that could cause shifting roles and functions in governing relationships. He describes first order governing as direct or local governing, second order as coordination and the third order as more of a monitoring function. The PB case uses a similar description to differentiate the roles and functions between those who deliver services in the community level, those who manage and coordinate the organization and those who monitor the organization. It is obvious that PB Health developed a bureaucracy and infrastructure by which to implement Board decisions, which led to issues of roles and relationships and accountability. For PB Health, this recognition of different



levels of governing and management was useful for acknowledging the various levels and functions of all those involved at the level of the communities, central office, and MSB. The other point is that governance suggests transition, which is often demonstrated through various kinds of management reforms and institutional renewal. Such was the case with the PBCN leadership in their efforts to develop an arms length relationship between politics and administration by separating the central Chief and Council administration and the PB Health Board and organization.

The idea of forging new relationships and creating more effective forms of governance is another applicable benefit for this study. The work of the OECD<sup>45</sup> implies that good governance reflects new governing entities characterized by a highly informed, participatory and educated public, and transparent organizations focused on enhancing institutional rather than State development. Mark Turner and David Hulme agree with this general idea that the nature and performance of public organizations are critical to developmental success, but they disagree with the narrow technocratic approach being promoted by the OECD to accomplish this by developing management systems, procedures and organization designs. They suggest that political considerations need to be included because public organizations operate in political environments and therefore must be able to address political issues of power and authority. This was very useful for the PB case because it was important to recognize that in order to better understand the governance of PB Health, it was necessary to describe how the Board and organization systemically accommodated its relationships with the various political authorities. Judith Gruber's concerns with controlling bureaucracies who operate in the political realm as policymakers are also

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<sup>45</sup> The Organization For Economic Cooperation and Development

relevant to the PB case in terms of pointing out the need to examine how accountability issues between the Board and health administration were dealt with because of their mutual influence on policy and decision making. While all of these discussions vary in terms of focus and opinion, they raise general themes having to do with issues of power, relationships, accountability and relationships and political culture, all of which are involved in arenas of public decision-making whether they are global, national or local in scope.

### ***TRENDS IN ABORIGINAL GOVERNANCE LITERATURE***

The trends dominating aboriginal governance literature since the 1980s with the advent of various self-government developments and program devolution policies have focused on the development of strong Band government and institutional capacity and more community participation. For example, Cornell and Kalt's study on American Indian economic development,<sup>46</sup> wanted to know why some tribes developed more successfully than others. They concluded that poverty was not solely a financing issue, it also involved a lack of strong institutions and policy capacities at the reserve level and what was needed to change this was a supportive political environment. The Harvard study implies that successful tribal service delivery institutions had to be professionally managed along Weberian management principles, have autonomous authority from political interference, and have appropriate policy development processes in place.

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<sup>46</sup> Cornell, Stephen and Joseph P. Kalt, Reloading the Dice: Improving the Chances for Economic Development on American Indian Reservations, Harvard Project on American Indian Development, John F. Kennedy School of Government, Harvard University, March 1992. Cited in the Royal Commission's Report, the Institute on Governance publications (1999), Robert Depew (1994)

Since that time aboriginal governments have continued to develop fairly extensive political and administrative capacities<sup>47</sup> at the Band level through broader coalitions or "aggregates"<sup>48</sup> at the regional, provincial and national levels. Regardless of the level of developments, however, the colonial-dependency theme<sup>49</sup> continues to dominate governance literature and while it is a useful descriptive context for situating First Nations, it also provides somewhat of a theoretical buffer against constructive empirical analysis of First Nation governments and organizations. This is changing, however, as First Nations governments are experiencing development issues of political legitimacy,<sup>50</sup> accountability,<sup>51</sup> and leadership<sup>52</sup> with their members much like other levels of Canadian government. Cairns, Depew, Hawkes and others including position papers put out by the Assembly of First Nations on governance issues,<sup>53</sup> suggest a change has occurred, an evolution or transformation of First Nations governments and organizations from a situation of powerlessness to one of

<sup>47</sup> Institute on Governance, Aggregation Among First Nations: A Handbook For Self-Government Negotiators, June 2001, 1; WotherSpoon Terry, Vic Satzewich, First Nations: Race, Class and Gender Relations, 1993, 92; Cassidy Frank, Robert L. Bish, Indian Government: Its Meaning in Practice, 1989, 10

<sup>48</sup> Institute on Governance, Aggregation Among First Nations: A Handbook For Self-Government Negotiators, June 2001, 2

<sup>49</sup> Robert Depew, in First Nations Organizations et.al., 1994, 39; C.E.S. Franks, 1984, in Canadian Public Administration, vol.27, no.2, 210-241; Assembly of First Nations, Report to a National Health Forum in Vancouver, Nov 1-3, 1995, 1996; O'Neil J. in Human Organization 45(2), 1986, 119-28; Young T.K. in Social Science and Medicine, 18(3), 1984, 257-64; Dyck Noel, in What is the Indian Problem et.al, 1991, 3, Smith T. Linda, Decolonizing Methodologies, 2002; Friesen, You Can't Get There From Here et.al, 1995

<sup>50</sup> Menno Boldt raises issues of legitimacy of band governments in Surviving as Indians, 1993

<sup>51</sup> Auditor General's Report on First Nations Health, 1997, 2000 recommending stricter financial and program accountability on First Nations

<sup>52</sup> Dan Smith, The Seventh Fire et.al., 1993, talks about a need for a new kind of inclusive politics in band government decisions; Stephen Cornell and Joseph P.Kalt, in Reloading the Dice et.al., 1992, did a study of developed tribes having effective institutions free from political interference

<sup>53</sup> Depew Robert C., in First Nations Organizations, et.al., 1994, Cairns in Governance in the 21<sup>st</sup> Century et.al., 2000, Assembly of First Nations in the First Nation Plan: First Nations Governance from a First Nations Perspective, 2002, AFN in Towards a New Transfer Perspective, 1996;



increasing strength, progress, and accommodation,<sup>54</sup> albeit still confined by federal and provincial policies.<sup>55</sup> Alan Cairns suggests that the "internal empire" of colonial wardship relations that marked Canadian history has been transformed by the "emergence of small self-governing Aboriginal Nations,"<sup>56</sup> that evolved in response to Aboriginal nationalism. In essence, First Nations have pushed the federal policy agenda away from a focus on wardship to self-government, and this has raised a more pressing and public awareness to deal with governance and issues of administration in their own communities.<sup>57</sup>

Many scholars promoting more study of contemporary aboriginal organizations, such as Robert C. Depew (1994), C.E.S. Franks (1987), David Newhouse (1993), Young and Smith (1982), John Hylton H., 1999), acknowledge that there is limited knowledge about the context and processes of institution-building among First Nations and their communities. Some like Depew, Smith and Young, for example, went so far as to formulate general analytical models blending the integration of both institutional and non-institutional factors, such as the influence of community culture, to help scholars study First Nation organizations.

Depew suggested using 4 themes or categories of organizing principles in his framework - manifest formations, latent formations, policy issues and environmental conditions."<sup>58</sup> Manifest formations referred to formal organizational structures and processes. Latent formations referred to community types and cultural diversity.

<sup>54</sup> Elias Peter Douglas, Development of Aboriginal People's Communities, North York, Ontario: Captus Press, 1991, 33

<sup>55</sup> Cairns, Alan C., "The End of Internal Empire: The Emerging Aboriginal Policy Agenda," in Governance in the 21<sup>st</sup> Century: Transactions of the Royal Society of Canada, Series VI, Vol X, 1999, Toronto: University of Toronto Press, 2000

<sup>56</sup> Cairns, Alan C., *ibid*, 122

<sup>57</sup> Auditor Generals Report, 1987, 1999, 2002

<sup>58</sup> Depew, Robert C., in First Nations Organizations, et.al., 1994., iii

Policy issues referred to the scope of authority, allocation, and State influence, and the environment covered contingencies and uncertainties such as the availability of human and financial resources. While Depew's categories were useful in the sense of recommending a holistic approach to the study of First Nations organizations,<sup>59</sup> especially his inclusion of latent or underlying influences of culture in the development of local institutions, they were applied in a limited way here because the focus of this thesis was on Board governance rather than the administration of the PB Health organization.

Young and Smith, likewise, developed a generalized holistic framework for studying First Nation health organizations, except that they were more specifically concerned with the details of how First Nations were making the transition from institution-centered to community-centered health care systems, how they were building local cultures of healthcare, how they were drawing upon support mechanisms and how they were collaborating with others.<sup>60</sup> They came up with 3 major themes or indicators characterizing what they considered to be an optimal participatory health model consisting of support mechanisms, organization and personnel, and treatment and effect. Support mechanisms referred to financial and policy supports by government. Organization and Personnel indicators referred to representative, accountable health authorities and committees with appropriately

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<sup>59</sup> Depew Robert C., *ibid*, 74-75

<sup>60</sup> Young David E., Leonard Smith, The Involvement of Canadian Native Communities in Their Health Care Programs: A Review of the Literature Since The 1970's, Edmonton, Alberta: Canadian Circumpolar Institute, University of Alberta, 1992, vi

trained health staff. Treatment and effect indicators referred to culturally appropriate health programs and services, including use of traditional medicine.<sup>61</sup>

As in the case of Depew's framework, Smith and Young's framework alluded to political culture through references to 'culturally appropriate' programming, and 'representative and accountable' health authorities, but their themes focused more on improving health programming and strategies rather than governance. They envisioned a more participatory, "Native Community Involvement in Health" (Native CIH)<sup>62</sup> strategy, which went beyond the more structural or institutional emphasis of the conventional Primary Health Care (PHC) model. Generally, PHC was a philosophical strategy adopted by Health Canada after the 1978 World Health Organization Alma-Ata Declaration that prescribed more public involvement in health and the improvement of patient access to basic health services through the development of structural or systemic supports in the health system.<sup>63</sup> Specifically the philosophy was based on building an integrated district health system blending both medical and other health related services, such as providing nutritious food, safe water, better sanitation facilities and health education among others.<sup>64</sup>

Other scholars on aboriginal self-government, also alluded to the importance of including cultural themes in the study of First Nation organizations through references to terms and phrases such as community empowerment,<sup>65</sup> cultural

<sup>61</sup> Young David E., Leonard Smith, *ibid.*, iv and 6

<sup>62</sup> Young David E., Leonard Smith, *ibid.*, 10

<sup>63</sup> World Health Organization, Alma-Ata 1978: Primary Health Care, Geneva, Switzerland: World Health Organization, 1978, 34

<sup>64</sup> Young David E., Leonard Smith, *op.cit.*, 5

<sup>65</sup> Dacks Gurston and Ken Coates, eds., Northern Communities: The Prospects for Empowerment, Edmonton, Alberta: Boreal Institute for Northern Studies, 1988, preface by G. Dacks



development,<sup>66</sup> community development,<sup>67</sup> and "strong" aboriginal communities with sufficient authority and institutional and policy-making capabilities.<sup>68</sup> All indicated an acknowledgment of the changing political culture of aboriginal peoples in general towards the control and establishment of less conventional bureaucratic organizations reflecting their own ways of doing things.<sup>69</sup> Such was the case for PB Health. The 1995 Health Transfer Agreement was reflective of this trend with its emphasis on increased community control and the design of a more "holistic community-based health delivery system."<sup>70</sup>

While the literature was significant in terms of recognizing cultural implications for institution building in First Nation communities, the continuing focus on Band governments failed to recognize that governance functions have expanded beyond political administrations to include non-government agencies delivering various types of services, like health and education, through different forms of governance such as community boards, committees and interagency networks. Minimizing the significance of these different governance systems, therefore, could lead to generalizations that minimize the more positive attributes and developments in First Nation communities. On the other hand, the significance of Band governments

<sup>66</sup> Elias Peter Douglas, Development of Aboriginal People's Communities, North York, Ontario: Captus Press Inc., 1991, 136-176

<sup>67</sup> Hylton John H., ed., Aboriginal Self-Government in Canada: Current Trends and Issues, Saskatoon, Saskatchewan: Purich Publishing Ltd., 1999, 439-442

<sup>68</sup> Institute on Governance, in collaboration with York University, CESO Aboriginal Services, Saskatchewan Federated Indian College, Understanding Governance in Strong Aboriginal Communities, Phase One: Principles and Best Practices From the Literature, October 12, 1999, i., <http://www.iog.ca/publications/strong-ab-gov.pdf>

<sup>69</sup> Indian and Northern Affairs Canada, First Nations Effective Practices: Getting Things Done In Aboriginal Communities, Businesses and Organizations, 1996, ([wysiwyg://96/http://www.ainc-inac.gc.ca/pr/pub/ep/intro-e.html](http://www.ainc-inac.gc.ca/pr/pub/ep/intro-e.html))

<sup>70</sup> PBCN Health Services Inc., 1995 Directional Plan, Prinee Albert, Sask.: 1995, 1, Executive Summary

also needs to be factored into any discussions on community governance because of their dominant political status.

In relation to policy literature on governance, the Institute on Governance produced much of the recent work and it added Aboriginal Governance as a special research agenda because of the issues arising out of self-governments such as the James Bay Agreement in northern Quebec and the Nishga and Sechelt Agreements in British Columbia. These have raised questions around what is aboriginal governance, what forms are culturally appropriate, effective and accountable,<sup>71</sup> what constitutes good governance, are different approaches to governance suited to different stages of development, and what are the attributes of aboriginal traditions of governance?<sup>72</sup>

Their main premise promotes the concept of citizen participation in public policy-making that they suggest is consistent with the thinking reflected in some Aboriginal languages that define government as "our way of life" or "our life." This is further supported in collaborative reports such as the one by York University, CESO Aboriginal Services and the Saskatchewan Federated Indian College on "Understanding Governance In Strong Aboriginal Communities."<sup>73</sup> Their handbook for Self-Government negotiators on "Aggregation Among First Nations" provides information on various governance models<sup>74</sup>, such as the case study of the Mi'kmaq Education Authority in Nova Scotia.<sup>75</sup> All of these were useful in illustrating the

<sup>71</sup> Papers are published in their website, [http://www.iog.ca/knowledge\\_areas.asp?pageID=2&area=1](http://www.iog.ca/knowledge_areas.asp?pageID=2&area=1)

<sup>72</sup> Plumtre Tim & John Graham, Governance and Good Governance: International and Aboriginal Perspectives, Institute on Governance, 1999, 2, quoting the Royal Commission on Aboriginal Peoples.

<sup>73</sup> Institute on Governance, Understanding Governance in Strong Aboriginal Communities, et.al., October 12, 1999

<sup>74</sup> IOG, Aggregation Among First Nations: A Handbook For Self-Government Negotiators, Ottawa: June, 2001

<sup>75</sup> IOG, Jennifer McCarthy, MI'KMAW INA'MATNEWEY: A Case Study in Aggregation, Ottawa: June, 2001

strengths and the gaps in the literature on First Nation governance models and they helped generate my interest in doing a more focused study on a form of distributed governance that has developed in northern Saskatchewan through service delivery models because this type of governance suggests a consistency with the First Nation cultural aspects of a holistic worldview, sharing and kinship values that are espoused by political leaders and self-government scholars. Robert Depew's theoretical framework for studying aboriginal organizations follows the same line of thinking as the Institute. His basic premise is that an organization has to fit the setting and given that Aboriginal people have their own distinct cultural, social and political values and practices, it is expected that their institutions are probably going to be different from mainstream society, and even among each other's communities.<sup>76</sup>

### **Recent Policies on Aboriginal Governance**

One of the more recent and influential government policy documents on Aboriginal governance is the 1996 Royal Commission of Aboriginal Peoples Report. The document portrays a dark history of the State's monopoly over the Aboriginal agenda where policies sought to undermine aboriginal institutions and family life through various assimilation instruments like the Indian Act, the creation of Band governments, residential schools, enfranchisement and loss of land and jurisdiction.

In reference to governance, the report made it evident that the history of Aboriginal policy had been 'steered' or dominated by a strong centralized government and its bureaucracy, with very limited input by the stakeholders or the public. It called for a renewed relationship between Aboriginal Peoples and the State within the federal framework. The vision is for a more fundamental, shared and

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<sup>76</sup> Depew, Robert C., in *First Nations Organizations, et.al.*, 1994, "forward"



participatory version of governance for the Aboriginal people. Whether or not attempts to renew this relationship will lead to improved conditions for Aboriginal people at the urban and reserve levels is debatable. Scholars like Alan Cairns<sup>77</sup> and Tom Flanagan<sup>78</sup> raise doubts about the practical and ideological problems associated with Aboriginal self-government. Marlene Brant Castellano, on the other hand, suggests that there is sufficient political will in Canada to renew a relationship of trust and respect. Self-government is already being shaped in First Nation communities through various landmark agreements with the governments of Canada. The implication is that Band governments and their governance systems are sufficiently developed and should be accommodated within a renewed federalism and rather than being portrayed as a threat to State power, should be viewed as an opportunity to build a more just political order and the common good.<sup>79</sup>

The extent to which the governance trend in Canada towards less government and more public participation had any impact on Aboriginal policy is debatable. However, the trend in Aboriginal literature carries a similar theme of removing the State's power over Aboriginal people and their issues and transferring it into them. The transfer of power has been to some degree accommodated by the State through administrative and program devolution arrangements with the Band governments. As well, the influence of Aboriginal political organizations has reached a certain level of political legitimacy with the State governments as representing individual member

<sup>77</sup> Cairns, Alan C., "The End of Internal Empire: The Emerging Aboriginal Policy Agenda," in Gilles Paquet, David M. Hayne, *Governance in the 21<sup>st</sup> Century*, Toronto: University of Toronto Press, 2000, 127

<sup>78</sup> Flanagan Tom, *First Nations? Second Thoughts*, Montreal: McGill-Queen's University Press, 2000, 7

<sup>79</sup> Castellano Marlene Brant. "Renewing the Relationship: A Perspective on the Impact of the Royal Commission on Aboriginal Peoples." *Aboriginal Self-Government in Canada: Current Trends and Issues*. Ed. John H. Hylton. Saskatoon, Saskatchewan: Purich Publishing Ltd. 92-109.

interests, although not to the extent described by Alan Cairns who suggested that Aboriginal nationalism ended the internal empire of the state. He argued that the State was going through a "transformation" partly as a response to the new emerging Aboriginal policy agenda directed towards more autonomy and self-government within an institutional and possibly constitutional framework.<sup>80</sup> Flanagan also agreed that Aboriginal nationalism was an influential vehicle in the shaping of public policy, but unlike Cairns, he believed that its demands could not be accommodated within the existing constitutional framework because the ideology behind the "inherent right to self-government" in practice was still oriented towards sovereignty.

Earlier work by scholars such as Frank Cassidy and Robert L. Bish, is still applicable to the current federal policy environment in relation to self-government. Indian governments are portrayed as a form of "domestic dependent nations,"<sup>81</sup> with delegated powers to administer federal and/or provincial community programs and services as a matter of policy. However, First Nations such as PBCN interpret administrative arrangements such as health service transfer agreements in a more positive manner as one of temporary accommodation where they assert inherent and independent jurisdiction on one level, but accept and implement delegated jurisdiction on another, for practical service delivery reasons. First Nation government, pre and post RCOAP is therefore still largely based upon the evolving

<sup>80</sup> Cairns, Alan C., in *Governance in the 21<sup>st</sup> Century*, et.al., 2000, 119

<sup>81</sup> Cassidy Frank, ed., *Aboriginal Self-Determination*, Winnipeg, Manitoba: Oolichan Books and the Institute for Research on Public Policy, 1992, 5

institutions of governance, such as Band administrations, boards, and committees and the various patterns of service delivery on reserves.<sup>82</sup>

The temporary accommodation theme is evident in the First Nation Governance Plan by the Assembly of First Nations which calls for four streams of change as being necessary for substantive change, namely, nation' rebuilding, redistribution of lands and resources, treaty implementation and new fiscal relationships. All of these are premised on the notion that the inherent right of self-government exists and is reflected in the Constitution. In dealing with the practical aspects of governance, they argue for more resources aimed at capacity building in all areas including Band administrations and service delivery institutions that address the First Nation values of accountability and inclusion.<sup>83</sup> In that sense, devolution policies like Health Transfer are seen as temporary administrative measures towards the road to self-government.

### Main Themes

The main themes selected to form the framework from the literature review on governance were power/authority, accountability, relationships and political culture. The themes in these various areas of self-government and First Nation organizations were relevant to this thesis insofar as they included the underlying relevance of non-institutional influences in the study of First Nation organizations, such as cultural appropriateness, community participation, representation, accountability, holistic programs and services, community control and authority, sufficient financial and

<sup>82</sup> Cassidy Frank, Robert L. Bish, *Indian Government: Its Meaning in Practice*, Lantzville, B.C.: Oolichan Books and the Institute for Research on Public Policy, 1989, 156

<sup>83</sup> Assembly of First Nations, *The First Nation Plan: First Nation's Governance From a First Nation's Perspective*, February, 2002



human resources. The themes generally reflected and built upon the earlier work of scholars including Depew, Young and Smith, and others, particularly in their recommendations that First Nations organizations should be studied through an integrated holistic lens, rather than the more singular and narrower institutional view.

The scope of most analyses on Aboriginal peoples in Canada situates them as a group within a colonial federal framework that provides for only two orders of government in its Constitution, and subordinates all other governments, including Aboriginal governments, under either federal or provincial authority. Theorists from various disciplines such as political science, law, public administration, sociology, anthropology, Indian-Native Studies, have used varying degrees of the colonial framework to try to explain Indian-State relations in terms of the failure of the State to deal with the so-called "Indian dependency problem" in Canada. Some portray the State as being too imperialist and somewhat conspiratorial in keeping Aboriginal people down so they don't have to respond to their demands for self-government; some blame the controlling nature of global capitalism in forcing the State to adopt fiscal and social policies aimed at creating an environment where the relations of production support the interests of capital; some criticize the Aboriginal people themselves for being co-opted into the capitalist system supported by State institutions, and helping to perpetuate their continuing dependency situation.

This thesis favors the more integrated perspective that portrays the State and Aboriginal governments as being engaged in a perpetual negotiation towards self-

government and improved co-existence. Katherine A. Graham<sup>84</sup> reflects a similar integrated view in her commentary of urban Aboriginal governance and discussions around emerging urban service associations such as Friendship Centers. She defines governance in terms of institutions, services and political arrangements and feels that urban Aboriginal governance could provide service delivery options for governments who are seeking alternative approaches. While Cairns feels that the Royal Commission failed to adequately address urban issues because of its biased focus on nation-government, Graham credits the Commissioners for raising alternative governance options for delivering public services through autonomous or co-managed aboriginal self-governing institutions in urban areas.

#### **Power and Authority and Accountability**

Power and Authority and Accountability are fundamental concepts in governance literature because they involve "institutions, processes and traditions for dealing with issues of public interest."<sup>85</sup> In the past, the concept of governance was generally applied in relation to the politics of government, but with the increasing importance in international and global institutions as well as the growth in local and regional governing authorities (like school boards), it has become essential to study both government and non-government agencies and their relationships in order to better understand the governing process.<sup>86</sup> These raise complex issues of power and authority and accountability, all of which are in themselves subject to extensive

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<sup>84</sup> Graham Katherine A., "Urban Aboriginal Governance in Canada: Paradigms and Prospects," in John H. Hylton, ed., Aboriginal Self-Government in Canada: Current Trends and Issues Second Edition, Saskatoon, Sask: Purich Publishing Ltd., 1999, 377

<sup>85</sup> Plumptre Tim, Toward a Governance Research Agenda, Ottawa: Institute on Governance, February 1998

<sup>86</sup> Mintz Eric, David Close, Osvaldo Croci, Politics, Power and the Common Good: An Introduction to Political Science, Toronto: Pearson Education Canada Inc., 2006, 326, 327

scholarly debates, but for the purposes here, "power" will refer to the institutional<sup>87</sup> and administrative authority delegated to PB Health through its enabling corporate documents and Health Transfer Agreement rather than the broader versions of power associated with political or "Band" government authority.

Governance usually refers to government activities where certain authorities are imbued with sweeping powers to make public decisions by some legislative or legal instrument. Power in this sense is respectively constitutional and legal, although legality does not necessarily mean legitimacy, since governing authorities can make decisions that are not necessarily acceptable to the public. The concepts of "power" and "authority" are linked in the sense that authority is an aspect of power. The Report of the Royal Commission on Aboriginal Peoples describes this linkage well where it defined "power" as "the acknowledged legal capacity to act,"<sup>88</sup> however, in order to make that legal authority effective, political recognition and support by other more powerful governments and institutions was also considered essential. In the PB case, having administrative authority was not enough. The PB Board also had to spend a lot of time and effort building community and political support in order to gain sufficient legitimacy to do their work. This meant balancing the relatively undefined political power relations with the Chief and Council while building the viability and legitimacy of a new organization. In other words the Board had to earn public confidence by proving they could do the job required of them.

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<sup>87</sup> Brodie Janine, Sandra Rein, eds., Critical Concepts: An Introduction to Politics, Third Edition, Toronto: Pearson Education Canada Inc., 2005, 8

<sup>88</sup> Report of the Royal Commission on Aboriginal Peoples, Volume 2, Restructuring the Relationship, Part 1, Ottawa: Minister of Supply and Services Canada, 1996, 164



The dictionary defines "power" as "the ability to do something, to have influence and control."<sup>89</sup> Power "involves getting people to act against their own desires or interests through coercion (fear, threats), inducements (bribes, rewards), or manipulation (e.g. selective information sharing)."<sup>90</sup> Weber defined power as "the chance of a man or a number of men to realize their own will in a communal action even against the resistance of others who are participating in the action."<sup>91</sup> A similar definition describing the general power of a board of directors in a corporation suggests that it is "imposing one's will upon the behavior of other persons."<sup>92</sup>

The concept of "authority" is more narrowly defined referring to "the power or right to give orders and make others obey or to take a specific action."<sup>93</sup> Those who govern operate on delegated authority giving them the right to govern and in most cases, the power (means and resources) to implement their decisions.<sup>94</sup> Authority raises issues of legitimacy and illegitimacy. Legitimacy refers to the public's acceptance that those in authority have the right to make decisions on their behalf. Conversely, illegitimacy refers to force or a failure by those in authority to follow institutional norms and expectations.<sup>95</sup> In the PB case, public support for the PB corporate model was reflected in the pre-Transfer community surveys and the

<sup>89</sup> Hawkins Joyce M., The Oxford Large Print Dictionary, Toronto, Canada: Oxford University Press, 1989

<sup>90</sup> Mintz Eric, David Close, Osvaldo Croci, Politics, Power and the Common Good: An Introduction to Political Science, Toronto: Pearson Education Canada Inc., 2006, 10

<sup>91</sup> Gerth H.H. And C. Wright Mills, From Max Weber: Essays in Sociology, New York: Oxford University Press, 1946, 180

<sup>92</sup> Gillies James, Boardroom Renaissance: Power, Morality and Performance in the Modern Corporation, Toronto: McGraw-Hill Ryerson Limited, 1992, 55

<sup>93</sup> Hawkins Joyce M., The Oxford Large Print Dictionary, Toronto, Canada: Oxford University Press, 1989

<sup>94</sup> Mintz Eric, David Close, Osvaldo Croci, Politics, Power and the Common Good: An Introduction to Political Science, Toronto: Pearson Education Canada Inc., 2006, 14

<sup>95</sup> Brodie Janine, Sandra Rein, eds., Critical Concepts: An Introduction to Politics, Third Edition, Toronto: Pearson Education Canada Inc., 2005, 8, 9

recognition of the PB Health Board having legitimate and legal authority in health matters was outlined in the Transfer Agreement, but even so, the Board still had to work hard at persuading the population to accept what that authority meant in practice. It meant that all matters relating to the administration of health services had to be taken to the PB Board and not the Chief and Council as was done in the past. By in large, however, as in most cases with legal authority in the larger society, the PBCN members acquiesced to the Board's legal authority and accepted it as legitimate although they may have disagreed with certain aspects of it.

The dictionary definition of "accountability" is "to give a reckoning or explanation for one's actions,"<sup>96</sup> and its application with respect to First Nation governance has usually been through federal government service contracts outlining conditions with respect to fiscal management, public answerability, and program performance. The Auditor General Reports (1987, 1999, 2002), for example, directed both of the key federal departments dealing with First Nations, the Department of Indian Affairs and the First Nations Inuit Health Branch of Health Canada, to enforce more strict financial and program controls in their funding Agreements.<sup>97</sup> It has also been defined in relation to contemporary First Nations development as "the management practice that defines key reporting relationships and the chain of command within an organizational structure."<sup>98</sup> In relation to PBCN, the Board was obligated to comply with the mandatory program delivery and reporting requirements

<sup>96</sup> Hawkins Joyce M., The Oxford Large Print Dictionary, Toronto, Canada: Oxford University Press, 1989

<sup>97</sup> Minister of Public Works and Government Services Canada, Report of the Auditor General of Canada to the House of Commons, Chapter 10-Indian and Northern Affairs; Chapter 13 - Health Canada-First Nations Health, Ottawa: 1997; Follow-up April 1999; 2000. Website for Health Canada - <http://www.oag-bvg.gc.ca/domino/reports.nsf/html/0015ce.html>

<sup>98</sup> *ibid.*, page 25, quoting Anderson Robert B., Economic Development Among the Aboriginal Peoples in Canada: The Hope for the Future, Captus Press, 1998, 170

of the Health Transfer Agreement by following the guidelines outlined in the PBCN Community Health Care Plan for delivering mandatory programs such communicable disease control, treatment services, and community emergency response plans.<sup>99</sup>

It has been generally assumed that Band governance has been changed and transformed in varying degrees across Canada, both on and off reserve, even though urban governance may not be as visible in the cities as it is on reserves. After decades of managing public services on their reserves, with varying degrees of successes and failures, Bands are facing issues of government and financial accountability much like the governments in broader Canadian society as noted by both Aboriginal and non-aboriginal scholars alike, such as Dan Smith,<sup>100</sup> Ronald Niezen,<sup>101</sup> Boldt (1993), Flanagan (2000), Noel Dyck (1991) and Cairns (2000).

The Auditor General, in the 1987, 1999, and 2002 reports noted similar concerns about financial accountability in Federal-Band agreements and recommended that they enhance stricter accountability and enforcement measures. The failed proposed First Nations Governance Act to amend the existing Indian Act also had the same theme of developing stronger public accountability and enforcement measures for Band governments. While the proposed legislation was shelved because of widespread political opposition by Aboriginal groups, the language behind the legislation was to make the Band government systems more accountable to Band members by transferring power to the hands of local people to

<sup>99</sup> The PBCN Health Services Inc., clause 7, Appendix 'F' of the "PBCN Health Services Transfer Agreement," Prince Albert, Sask.:1995

<sup>100</sup> Smith Dan, The Seventh Fire: The Struggle for Aboriginal Government, Toronto: Ontario: Key Porter Books Ltd., 1993, 238

<sup>101</sup> Niezen Ronald, "Telling a Message: Cree Perceptions of Custom and Administration, in The Canadian Journal of Native Studies, 13(2): 221-250, cautions against appropriation of culture in the goal to develop culturally appropriate institutions; similar concerns shared by Menno Boldt, Robert Depew.



ensure their governments work for them.<sup>102</sup> The Assembly of First Nations, while not disagreeing with the general theme for more political and financial accountability by Band governments criticized the federal government's consultation process as being invalid for not allowing enough time for a proper review and felt that the amendments narrowed the scope of governance to 'tinkering' with the Indian Act and did not allow for substantive change to happen in self-government.<sup>103</sup>

These concerns with power and accountability at the broader governance level were generally reflected in the PB Health Transfer Agreement. The power/ authority and accountability of the PB Board flowed from their contractual relationship with the federal government (MSB Health Canada) and the PBCN Chief and Council in the Health Transfer Agreement.<sup>104</sup> Under the non-profit legislation, the authority was vested in the Board as a group and not as individuals, therefore, decisions affecting the organization had to be made by the whole Board with the exception of decisions delegated to others, such as the authority delegated to the management and staff for day-to-day operations.

The Health Transfer Agreement was a tripartite agreement signed on March 17, 1995 between PBCN, MSB and PBCN Health Services Incorporated.<sup>105</sup> It gave the PB Board the authority to manage and provide health services to the members of the PBCN residing in the communities of Southend, Pelican Narrows, Sturgeon

<sup>102</sup> First Nations Governance: The Proposed First Nations Governance Act in DIAND website: [wysiwyg://1/file:/A/First Nations Gove...opposed First Nations Governance Act.htm](http://wysiwyg://1/file:/A/First%20Nations%20Gove...opposed%20First%20Nations%20Governance%20Act.htm)

<sup>103</sup> AFN, Assembly of First Nations Summary Analysis: Validity of DIAND'S consultation Process for the First Nation's Governance Legislation Initiative, Jan., 2002

<sup>104</sup> PBCN Health Transfer Agreement, clause 3, Prince Albert, Sask: 1995

<sup>105</sup> PBCN Health Services Inc., Pamphlet entitled. "Peter Ballantyne Cree Nation Health Services Transfer: Working Together Towards Healthy Families and Communities," Prince Albert, Sask: 1995

Landing and Deschambault Lake, and anyone requiring emergency services.<sup>106</sup> The PB Board was responsible for ensuring the following objectives were met:

1. "Design health programs, establish health services, and allocate funds according to Band community health priorities;
2. Ensure public health and safety is maintained by providing mandatory health programs; and
3. Strengthen and enhance the accountability of the Band's health services to community members."<sup>107</sup>

The Transfer Agreement was described as an administrative contract for the performance of a service or program and that PBCN Health Services was an "independent contractor" engaged in the sole purpose of providing a service or program and responsible for all complying with federal and provincial laws relating to non-profit organizations.<sup>108</sup> The primary political authorities and signatories were the PBCN Chief & Council and Minister of Health Canada (MSB). The Agreement, however, was that the Minister and PBCN agreed that the "delivery, administration, provision, and control of health services by the Band" would be "assigned to the PBCN Health Services Inc., which undertook to perform all requirements of the Agreement in respect of the "delivery, administration, provision and control of health services."<sup>109</sup> This meant that the Board had a corporate and contractual responsibility

<sup>106</sup> PBCN, PBCN Health Services Inc., Minister of National Health and Welfare Canada, The PBCN Health Transfer Agreement, 1995, PBCN Health Services Inc.: Prince Albert, Sask.: March 17, 1995, s.6

<sup>107</sup> The Minister of National Health and Welfare, The Peter Ballantyne Band, The PBCN Health Services Inc., The Health Service Transfer Agreement, 1995, Prince Albert, Sask.: 1995, pg2

<sup>108</sup> PBCN, PBCN Health Services Inc., Minister of National Health and Welfare Canada, The PBCN Health Transfer Agreement, 1995, PBCN Health Services Inc.: Prince Albert, Sask.: March 17, 1995, s.55

<sup>109</sup> PBCN, PBCN Health Services Inc., Minister of National Health and Welfare Canada, The PBCN Health Transfer Agreement, 1995, PBCN Health Services Inc.: Prince Albert, Sask.: March 17, 1995, s.3

to the PBCN Chief and Council as trustees of the PBCN membership and to MSB as the primary funding agency. Their accountability to the community members was through Chief and Council and through general references to reporting requirements at public meetings.

### **Key Relations**

The Board relations with the other key players in the Transfer included the signatory partners (MSB,<sup>110</sup> Chief and Council), the Health Administration, the Community and other service agencies. The focus on Board – key player relationships helps illustrate and profile the work of the PB Health Board in their management of the PB Health Transfer. Easton's systems analogy and artificial box constructs describing state and society relationships, although limited to state functions, provide a useful albeit limited way of describing complex interactions within particular environments. One can envision PB Health as being an entity operating within a larger system and environment and consequently being influenced in varying degrees by both internal and external interests. It recognizes that governments and other governing entities do not operate in isolation of one another and that the influences of other interests need to be considered when describing how decisions are made.

The key relations for the PB Board are therefore described here in terms of both internal and external influences. The internal relations refer to the Board–Administration relations with the managers and staff of PB Health. The external elements refer to relations with other key players in the Transfer, such as “the governments,” with MSB representing the federal government and the PBCN Chief

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<sup>110</sup> Medical Services Branch of Health Canada



and Council representing the First Nation government, as well as the "PBCN Community" and "other" agencies.

More detail is spent on the internal relationships with the 'Administration' or health staff simply because the Board had more direct and frequent and documented interactions with them than any other group. The same applied to the relations with 'MSB' who were involved because of ongoing funding concerns, and the relations with 'Chief and Council' who were closely involved with the Board through activities in the communities, especially the portfolio councilors, who were members of the community health committees and attended Board meetings as ex officio members. On the other hand, the relations with the 'community' and 'other' agencies were not individually described as extensively because they were integrated into the Administration and Chief and Council sections. Community people were not as directly involved in Board decisions in the sense of mass decision-making or policy-making techniques such as referendums, but were involved through either personal contacts, political representation, or with their daily contacts with the administration or health staff at the health centers. These interactions were not usually documented, unless they were matters of political or health significance. The relations between the Board and "other" agencies were also not as direct or frequent and were mostly done through the administration channels.

### **Political Culture**

Political Culture is one of the issues raised in this thesis as being important to the discussion of PB Health governance, along with power, relationships and accountability. Political culture, as it is applied here, is simply a reference to

generally observed group behaviors and political orientations over time, although references to public opinion surveys used throughout the PB Health experience may be used by implication to describe a political environment at a certain point in time regarding health-related issues. Political culture, therefore, is a means of describing the general attitudes and behaviors of the community people and the Chief and Council towards the work of the PB Health Board and organization as reflected in the experiences of the Board in their relations and interactions with the communities. It helps provide an environmental context to better understand the work of the Board and the general level of community support and understandings that that the PBCN members had towards the Board and organization.

Although political culture is used in a broad context here, the notions of group cultural values and practices and their influence on governing institutions are sufficiently appropriate for describing the experiences of the PB Board. James N. Danziger describes political culture "as the configuration of a particular people's political orientations-that is, as the generalized belief system of many."<sup>111</sup> Alan Ball suggests that it is "composed of the attitudes, beliefs, emotions and values of a society that relate to the political system and to political issues. These attitudes may not be consciously held, but may be implicit in an individual or group relationship with the political system."<sup>112</sup> It has also been described as "a term popularized by Gabriel Almond that refers to a particular patterned orientation toward political action. The

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<sup>111</sup> Danziger James N., Understanding The Political World: A Comparative Introduction to Political Science, Seventh Edition, New York: Pearson Longman 2005, 31

<sup>112</sup> Ball Alan R., Modern Politics and Government, 2<sup>nd</sup> Edition, Hong Kong: The MacMillan Press Limited, 1997, 21

political culture approach tries to empirically describe and explain these patterns by measuring the attitudes characteristic of a national population."<sup>113</sup>

The term political culture is generally attributed to the work of Gabriel Almond, a leading behavioral political scientist in the 1950s, who tried to identify a relationship between public opinion and the making of public policy.<sup>114</sup> The term was also attributed to Almond's later work with Sydney Verba in 1963 where, after studying the political cultures of Mexico, the United States, the United Kingdom and Germany, they came up with a typology of three distinct types of attitudes that people had towards political participation, namely, the parochial, subject and participant cultures. The "parochial" culture was where people did not expect to participate and did not make demands. The "subject" culture was where people did not expect to participate, but they did expect the political system to meet their needs. The "participant" culture was where people expected to participate actively and expected to get returns from the political system. For Almond and Verba, the most stable political system consisted of an ideal "civic culture" characterized by democracy and limited citizen participation.<sup>115</sup>

Almond and Verba were criticized for being "too ethnocentric and ahistorical"<sup>116</sup> in interpreting their survey findings into broad generalizations depicting the western cultures of the United States and the United Kingdom as examples of ideal "civic cultures," and for ignoring historical differences. In terms of

<sup>113</sup> Brodie Janine, Sandra Rein, *Critical Concepts: An Introduction to Politics: Third Edition*, Toronto, Ontario: Pearson Prentice Hall, 2005, 359, glossary

<sup>114</sup> Brodie Janine, *ibid.*, 2005, commentary by Yasmeen Abu-Laban on political cultures, 190-193; also, Khan Rais, McNiven James, *An Introduction to Political Science, 4<sup>th</sup> Edition*, Scarborough, Ontario: Nelson, Canada, 1991, 73

<sup>115</sup> Brodie Janine, *ibid.*, 2005, commentary by Yasmeen Abu-Laban on political cultures, 192

<sup>116</sup> *ibid.*, 192



this thesis, a further criticism of this kind of typology casting of ideal political systems, is that the references to political cultures described by Almond and Verba were limited to the political behaviors within a national state and excluded any references to internal group dynamics and political histories within a national state such as those described by Will Kymlicka as "national minorities" living alongside the majority culture.<sup>117</sup> Any exclusion of Aboriginal or Indigenous peoples in governance discourse involving Canada with its long historical contacts with the colonization policies of both the United States and the United Kingdom, therefore, could potentially lead to inadvertently making untruthful generalizations and unjust stereotypes, and on the other hand, not recognizing the influence of State government and the larger society on Aboriginal life could also be equally untruthful and potentially unjust. In that regard, this case seeks to integrate both the internal and external influences in the Board discussions in an effort to better describe the real governance experiences of the Board and the relationships they had to balance.

Notwithstanding these limitations, however, the term itself is useful in acknowledging the relevance and influence of community culture upon institutional development, such as that experienced by PB Health. Although the word or concept of "political culture" has not been specifically raised or defined in governance literature, it has been implied in much of the literature advocating a "cultural relativity"<sup>118</sup> theme to the study of Aboriginal organizations, in healthcare<sup>119</sup> as well

<sup>117</sup> Kymlicka Will, Multicultural Citizenship: A Liberal Theory of Minority Rights, London: Oxford University Press, 1995, 10

<sup>118</sup> Depew Robert C., First Nations Organizations: An Analytic Framework, Ottawa, Ontario: Research & Analysis Directorate, Indian and Northern Affairs Canada, July 1994, 9-10

<sup>119</sup> Young, D. and L. Smith, The Involvement of Canadian Native Communities In Their Health Care Programs: A Review of the Literature Since the 1970's, Edmonton, Alberta: Canadian Circumpolar Institute/Centre for the Cross-Cultural Study of Health and Healing, University of Alberta, 1992, 10;

as other sectoral areas<sup>120</sup> under First Nation self-government. There is a general agreement that the trend is changing towards an effort to design more culturally appropriate and effective forms of Aboriginal self-government, rather than perpetuating the more conventional forms of bureaucratic organization generally being espoused by both management practitioners in government and public administration theorists.

Political culture was therefore included as a theme here to help describe and better understand the nature of the relations and interactions between the PB Health Board and people in the communities. It was evident from the repeated references by the PB leadership, Board and community members in the various organization documents<sup>121</sup> for more local control and community development, enhanced accountability, holistic approaches to health and community participation, that as a whole PB political culture was very localized and that it was important for the Board, as a regional governing entity, to understand this general political nature of the communities in order to make appropriate decisions and to guide or "steer" the organization and staff in a direction that was more or less in line with the priorities of the communities.

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also Moore, M., H. Forbes and L. Henderson, 1990., "The Provision of Primary Health Care Services Under Band Control: the Montreal Lake Case," in Native Studies Review, 6(1):153-64

<sup>120</sup> Haig-Brown Celia, Taking Control: Power and Contradiction in First Nation's Adult Education, Vancouver, B.C.: UBC Press, University of British Columbia, 1995; also Franks. C.E.S. Public Administration Questions Relating to Aboriginal Self-Government, Kingston, Ontario: Institute of Intergovernmental Relations, 1987; also Newhouse David, A Report of the Working Group on Native Management and Economic Development, Peterborough, Ontario: Native Management and Economic Development Program, Trent University, 1993; also Hylton John H., Aboriginal Self-Government in Canada: Current Trends and Issues, Saskatoon, Sask.: Purich Publishing Ltd., 1999

<sup>121</sup> PBCN., The 1995 Health Transfer Agreement, Pelican Narrows, Sask: PBCN Health Services Inc., 1995, 2; also, PBCN Community Health Care Plan, January 1995, 7, 8; Also, PBCN Health Services Directional Plan 1995, 4-7; Also, PBCN Health Services Inc., Community Development Program, September 1995, 1, 2

It is assumed that political culture did influence the decisions of the PB Health Board, and because things like kinship relationships and Chief and Council governance practices were a reality in the communities, any decisions the Board made would have a reciprocal influence. It follows that if the Board were able to create good working relationships, then it is more than likely that they were able to adapt to the general political culture of the communities and to create the necessary working environments to enable them to do their work properly. For example, the people's attitudes and general support toward the work of the Board and organization during the five-year period was consistently reflected in periodic community surveys, which suggest that people were generally satisfied with the work of the Board. Among the contributing factors were the visible enhancements in the communities. Some of the new health programs included telehealth, dental services, local employment and training opportunities, new building projects, business developments such as the new pharmacy and ambulance, the blending of medical and other support services such as counseling, youth and elder programs in the health centers, interagency collaboration and partnerships with other local services and external health agencies, and above all, the Board's ability to do all this under balanced budgets.<sup>122</sup> These developments in the communities likely contributed to the growing legitimacy and acceptance of the Board and organization as a politically appropriate governance model for health services.

On the other hand, in cases where the Board went against the general political culture, such as the longstanding patterns of community people to take all their

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<sup>122</sup> PBCN Health Services Inc., "the Chief's Message," in the PBCN Health Services Inc., Annual Report, 1999-2000, Prince Albert, Sask.: PBCN Health Services Inc., 4



problems to Chief and Council, rather than to the various managing sectors such as health or education, it can be assumed that there would be more complaints to Chief and Council with community people trying to get their voice some other way. The credibility of the Board in trying to change these long-standing patterns by developing administrative policies to streamline community complaints about health to the appropriate managers was largely dependent on the support and adherence by Chief and Council and by the management and staff of the organization. As Chief and Council referred more and more community complaints to the appropriate managers and as the managers and staff responded in ways that were generally acceptable to the people, the Board were able to spend their efforts in building the work of the organization, rather than putting out political fires and getting pulled into day-to-day operational matters. Through this whole process, the correlation between the Board and management was significant because the work of the Board was only as good as the management.

Another aspect of the relevance of political culture as a theme in this thesis had to do with the representation role of the Board members themselves. All of the 10 Board members came from the PBCN communities and their job was to represent the health interests of their home communities at a regional level. They could not be elected politicians, but they had to meet general criteria as far as experience and interest in local health matters. In terms of being attuned to the PB political culture in general, the local representation model of the Board was set up based on the assumption that they would be more culturally sensitive to the values and priorities of their home communities and therefore, would be able to make more culturally

appropriate decisions. They did not need to go through a huge learning curve as far as community culture was concerned. Unlike the other provincial and regional health boards, the PB Board were more visible, directly accessible and hence more legitimate to the people they represented in their own home communities. The Board members had very personal stakes in ensuring that the health programs and services were being managed and delivered properly. The assumption that community representative boards, like PB Health, would be more politically and culturally sensitive to local priorities, seemed to bear out in this case. There was almost an implicit expression of community political culture through the Board members themselves. They grew up and continued to reside in the communities they were representing and could see first hand, if their involvement in the PB Health Board was making positive changes in their communities. They governed their meetings like any other community Band meetings in the north with flexible agendas and room for community members to bring their concerns forward.

The tendency of Board members was to advocate for their families and communities, rather than for themselves. They saw their Board representation as a serious and personalized responsibility. What they got in exchange was limited to being compensated for attending meetings and from time to time, attending Board development and other training workshops within prescribed budgetary limits. The Board generally approached decisions with communal deliberation. They seldom had confrontations, and even when there were disagreements, the majority will of the Board was accepted, although great pains were taken to try to address whatever situation was being presented. This did not mean, of course, that everyone was always

happy with the decisions, but there was general acceptance with the Board being able to move on and work together in other things.

Notwithstanding the productive work and individual strengths of the PB Board, another perspective could attribute their general stability and the support they got in the communities to their political linkages to Chief and Council. Since the Chief and Council had to approve the tenure of all the Board members through Band Council Resolutions, conceivably the Board members were approved partly because they were also political supporters of the various Councilors in the communities. Although political allegiance was not a formal requirement to be a Board member, and certainly nobody admitted to it, all those who sat as Board members in the first 5 years of Health Transfer had close personal linkages to the politicians, either as relatives, friends or members of large family voting blocks – suggesting that by and large, political support may have been as important as the other formal requirements for local experience and interest in health. On the other hand, since everyone was so interrelated in the communities, attributing patronage along these lines could also be questionable.

What is clearer, however, is that the PBCN political culture was generally localized, personalized and kinship-oriented, much like other reserves described by various scholars, although how culturally correct these are is uncertain. Contemporary political culture on reserves has generally been described along a spectrum of competing perspectives from negative, to somewhere in-between, to positive. On the negative side, references are made to lack of trust,<sup>123</sup> competition and almost

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<sup>123</sup> Smith Dan, *The Seventh Fire: The Struggle For Aboriginal Government*, Toronto, Ontario: Key Porter Books Ltd., 1993, 238



permanent discontent with the political leadership,<sup>124</sup> political nepotism or favoritism, and lack accountability.<sup>125</sup> The in-between side acknowledge that while political "divisions" and "problems" exist in reserves, competing interests are being balanced by various kinds of local and regional institutional developments linking citizen participation in their processes.<sup>126</sup> On the positive side, references are made to enduring traditional values such as direct citizen involvement, consensus decision-making, elder's advice and public meetings.<sup>127</sup>

Menno Boldt, for example, depicted Indian reserves in terms of unequal economic and class structures between the haves and have-nots. For him, the "Indian ruling class elite,"<sup>128</sup> of influential landowners, politicians, bureaucrats and business people controlled the lower classes (those on welfare) along kinship lines and the self interested cooperation between bureaucrats (usually relatives) and elected officials. He implied that until reserves got politically and administratively organized and mature, the federal government needed to continue to regulate the political and fiscal behaviors of the Band governments.

<sup>124</sup> Litham Yngve Georg, The Community Apart: A Case Study of a Canadian Indian Reserve Community, Winnipeg, Manitoba: The University of Manitoba Press, 1984, 167

<sup>125</sup> Boldt Menno, Surviving As Indians: The Challenge of Self-Government, Toronto: University of Toronto Press Incorporated, 1993, 131;

<sup>126</sup> McCarthy Jennifer, Mi'Kmau Kina' Matnewey: A Case Study in Aggregation, Ottawa: Institute on Governance, June 2001; also Plumptre Tim and John Graham in Governance and Good Governance: International and Aboriginal Perspectives, December 3, 1999, quoting Cornell, Stephen and Joseph P. Kalt, in "Reloading the Dice: Improving the Chances for Economic Development on American Indian Reservations," Harvard Project on American Indian Development, John F. Kennedy School of Government, Harvard University, March 1992, 10

<sup>127</sup> Cassidy Frank, Robert L. Bish, Indian Government: Its Meaning in Practice, Lantzville, B.C.: Oolichan Books and the Institute for Research on Public Policy, 1989, 77; also, Plumptre Tim & John Graham, Governance and Good Governance: International and Aboriginal Perspectives, December 3, 1999, 23 quoting the Royal Commission on Aboriginal Peoples Report describing attributes of traditional governance.

<sup>128</sup> Boldt Menno, Surviving As Indians: The Challenge of Self-Government, Toronto: University of Toronto Press Incorporated, 1993, 130-132

Wayne Warry, on the other hand, while agreeing with the divisive nature of political culture on reserves that he attributes to the competitiveness in Band electoral systems, believed that kinship factors could not be removed in Band systems. He suggested that most allegations towards misconduct or patronage by politicians were not based on fact, but rather attributed to people feeling left "out of decision making" processes or "wronged in a variety of ways,"<sup>129</sup> and that these complaints will likely continue even in cases where Bands go to great lengths to ensure transparency and accountability in their hiring and decision-making processes.

On the more positive side, Cassidy and Bish<sup>130</sup> described community political culture in terms of diversity and evolving institutions of practice – some traditional, some contemporary and some mixed. In spite of the diversities, however, Cassidy and Bish suggested that the general political patterns in First Nation communities continued to be based upon "consensus decision-making; elders and others knowledgeable of traditional ways; and public meetings."<sup>131</sup> It portrayed a rather benevolent political culture in a fashion similar to Lithman's description of a politicized community where "the bi-annually elected chief and council exercises its discretion in decision-making, and are held accountable at band meetings."<sup>132</sup> For Lithman, however, it was the politicized groups or "bunches" of families and the coalitions between them that were inherently the organizational device helping regulate the distribution of Band resources through their influence on the politicians.

<sup>129</sup> Warry Wayne, Unfinished Dreams: Community Healing and The Reality of Self-Government, Toronto: University of Toronto Press Inc., 1998, 235

<sup>130</sup> Cassidy Frank, Robert L. Bish, Indian Government: Its Meaning in Practice, Lantzville, B.C.: Oolichan Books and the Institute for Research on Public Policy, 1989

<sup>131</sup> Cassidy Frank, Robert L. Bish, *ibid*, 77

<sup>132</sup> Litham Yngve Georg, The Community Apart: A Case Study of a Canadian Indian Reserve Community, Winnipeg, Manitoba: The University of Manitoba Press, 1984, pg142

It is quite evident therefore, that scholars and others have many different interpretations about reserve political culture in general, but there also seems to be general agreement in describing it in terms of close and personalized family and kinship lines, or as Noel Dyck put it, where "members are bound to one another by dense networks of overlapping, face-to-face relationships."<sup>133</sup> This thesis is also in general agreement with this general assumption of First Nation political culture. It portrays the PB political culture as being localized, family oriented and personal. It helps describe the general political environment that the PB Health Board had to work in.

### **Conclusion**

The governance of public programs has increasingly been decentralized to non-government agencies accountable to community boards making the contact between the citizen and state in this area at the point of service delivery or what are sometimes referred to as first level services. The emphasis on a participatory agenda has helped to expand governance research to include both societal and state influences in the study of public service delivery systems. The essentially political nature of policymaking and program implementation has also been recognized therefore resulting in the consideration of community factors such as political culture, relationships, authority and accountability.

The disadvantages to the governance approach as an explanatory framework are that factors such as informal and formal authority structures are intangible, desired outcomes like success, for example, are also vague, and even when there are

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<sup>133</sup> Dyck Noel, What is the Indian Problem: Tutelage and Resistance in Canadian Indian Administration, St. Johns Newfoundland: The Institute of Social and Economic Research, Memorial University of Newfoundland, 1991, 144



tangible outcomes, like completing a project or employment, it's still hard to pinpoint the organization's contribution to goal indicators such as improving the health of the community. Nevertheless, the governance framework does offer an organized way for describing the emerging new governance models in Aboriginal communities.

### CHAPTER 3

#### The History of the Peter Ballantyne Cree Nation

##### Introduction

The intention of this chapter is to provide a historical context regarding the traditional governance of the Peter Ballantyne Cree Nation<sup>1</sup> in order to better understand how their traditional values and practices influenced the development of the PBCN Health governance model. The application of the governance framework to PBCN history with its emphasis on the distribution of power, relationships and accountability within a society or group,<sup>2</sup> recognizes the importance and influence of both formal and informal authority systems and the relationship between them.<sup>3</sup> It addresses questions such as: How did the Peter Ballantyne Cree Nation people govern themselves in the past? What kind of traditional authority system did they have and how were the issues of power, relationships and accountability distributed in that system? And what kind of influence, if any, did the values and practices of the traditional system have in shaping the current PBCN model of health governance?

This chapter addresses these questions by examining the historical values and practices of the PBCN people in terms of how they governed themselves as a "hunting-gathering society,"<sup>4</sup> the impact of the fur trade and Christianity upon their

<sup>1</sup> Hereinafter referred to as PBCN

<sup>2</sup> Plumptre Tim, John Graham, Governance and Good Governance: International and Aboriginal Perspectives, Institute on Governance, December 03, 1999, 3., provide a useful theoretical construct of governance framed around power, relationships and accountability: Who has influence, who decides and how decision-makers are held accountable.

<sup>3</sup> Lynn Laurence E. et.al. in "Studying Governance and Public Management: Why? How?" in Heinrich Carolyn J & Laurence E. Lynn, Jr., eds., Governance and Performance: New Perspectives, Washington, D.C.: Georgetown University Press, 2000, 8, suggests that the governance research includes contextualizing both formal and informal authorities in the determination of their impact on policy and programming.

<sup>4</sup> Brightman Robert E., Grateful Prey: Rock Cree Human-Animal Relationships, University of California Press, Berkeley and Los Angeles, California: 1903, 11, the ancestral accounts of people living in the pre-Cambrian areas, or the Churchill River drainage in what are now northern Saskatchewan and Manitoba, are referred to as "winter hunting groups," 11, "foraging societies,"

traditional systems, their domination by State authority through federal legislative and policy instruments such as treaties, the Indian Act, Indian Affairs administration and the impact of provincial laws and policies in the north.<sup>5</sup> The influence of all these in the shaping of their contemporary forms of band government and political culture will help to explain the cultural environment from which the PBCN Health organization evolved.

The Peter Ballantyne people do not have a comprehensive written history, indeed as anthropological scholars note; "source material on Western Woods Cree is unsatisfactory for most periods of their history."<sup>6</sup> Therefore the description of PBCN history presented here, is at best a speculation as to the meaning of traditional governance values because it is dependent upon information gathered from oral history as described in various research and government reports<sup>7</sup> as well as older accounts from the mid-19<sup>th</sup> century Hudson Bay Company fur trading post journals, and the narrative records of Indian Affairs Agents in the Indian Affairs Annual Reports from 1864 to 1990. Nevertheless, the intention is to provide a balanced and hopefully more realistic description of traditional PBCN life and to avoid what John

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with broad ethnic classifications as "Rock or Missinippi Crees" who speak the "woods Cree" or "th" dialect., 5

<sup>5</sup> Beatty Bonita, *The Transformation of Indian Political Culture in Northern Saskatchewan*, Unpublished Master's Thesis, 1996, p. ii. The formative change factors were put into broad themes – fur trade (1650-1867), state development (1867-1945), post war growth (1945-1970), and the modern era (1970-1990) – these themes are adapted in this case study to focus upon PBCN.

<sup>6</sup> Brightman Robert, *Grateful Prey: Rock Cree Human-Animal Relationships*, Berkeley and Los Angeles, California: University of California Press, 1993, quoting James G. E. Smith (1981: 270) on p. xii

<sup>7</sup> Phillip Ballantyne et.al. *Aski Puko: The Land Alone*, Saskatoon: Office of the Treaty Commissioner, 1976, was a research study done by the PBCN and Lac La Ronge bands on the effects of a proposed hydro-electric dam at Wintego Rapids upon the Cree of the Churchill River Basin, also the provincial government report by A.H. MacDonald, chairman, *Churchill River Board of Inquiry Report*, Saskatoon: 1978, had useful historical information. Ron Merasty's narrative history on PBCN taken from HBC trading post journals and other sources provided a more specific context confirming the general history of the PBCN people living in the "northern" regions of Saskatchewan as described in the Indian Affairs Annual Reports.



Friesen calls the tendency by Indian writers to "paint a more positive picture of the old way of life rather than presenting a purely descriptive view or analyzing inconsistencies and deficiencies therein."<sup>8</sup>

The ancestors of the Peter Ballantyne people have been characterized as the Rock or Misinipi Cree living in the northern regions of what are now the provinces of Saskatchewan and Manitoba. Robert Brightman's studies of the Rock Cree of Granville Lake and Pukatawagan in northern Manitoba suggests that the descendants of the historical populations living in the Churchill River Region were related by linguistic, territorial and social ties. They were part of what J.G.E. Smith categorized as Western Woods Cree consisting of the Swampy, Thickwoods and Rock groupings.<sup>9</sup> The Swampy Crees of the "n" dialect occupied the Hudson Bay Lowlands and forest edge areas of Manitoba, Saskatchewan and Ontario. The Thickwood Crees who spoke northern varieties of the "y" dialect lived in the forest areas of Saskatchewan, Alberta and Northeast British Columbia.

The Rock Crees spoke the "th" dialect and occupied the Churchill River drainage area of northern Manitoba and Saskatchewan and were referred to as "Asiniskaw-ithininiwak"<sup>10</sup> and "Assin'skowitiniwak,"<sup>11</sup> both meaning the people of the rocky area or Precambrian shield. Their historical occupation covered the north central regions from Lac La Ronge and Montreal Lake to the north-eastern regions of

<sup>8</sup> Friesen John W., The Cultural Maze: Complex Questions on Native Destiny in Western Canada, Calgary, Alberta: Detselig Enterprises, 1991, 27

<sup>9</sup> Brightman Robert E., op.cit., 4, 5 quoting Smith, James G.E., 1981. "Western Woods Cree" in J. Helm, ed., Handbook of North American Indians. Vol.6, Subarctic. Washington D.C.: Smithsonian Institution

<sup>10</sup> Brightman Robert E., ibid., pg .5

<sup>11</sup> Merasty Ron, A portrait of the Peter Ballantyne Cree Nation, Prince Albert, Saskatchewan: taken from a binder of Merasty's unpublished personal writings and archival material on PBCN history, 1

Brochet, Southern Indian Lake and Nelson House in Manitoba,<sup>12</sup> and while there is debate as to whether the Churchill Crees were migrants from the east during the westward migration of the early 19<sup>th</sup> century, it is generally agreed that the Rocky Cree were likely traditional occupants to the area.<sup>13</sup> Archaeological findings of pottery shards dating back 1600 to 1900 years ago found at the Two Rivers, Royal lake, Trade Lake, Sandy Bay, Sturgeon-Weir and Frog Portage were attributed to the late prehistoric Crees of northern Saskatchewan, although the sources of the projectile points or arrowheads found in various points of the Churchill River dated 3500 to 5000 years remain unknown and claims are uncertain.<sup>14</sup>

### **Kinship Traditional Authority System**

Ethnographic speculations about the pre-contact Cree way of life in northern Saskatchewan suggest the household as being the primary social structure with the family being the basic unit of production.<sup>15</sup> These pre-contact sub-arctic societies have been described as having adaptable social systems with nomadic, small independent households made up of closely related families.<sup>16</sup> This is consistent with the oral and written accounts describing the people of the Pelican Narrows region as being scattered over the north from Beaver Lake to the Churchill River with no

<sup>12</sup> Merasty Ron, *ibid*, 2

<sup>13</sup> Merasty Ron, *ibid*, in *Introduction* paper, 7 quoting J.G.E. Smith., 1981: 257

<sup>14</sup> Merasty Ron, *ibid*, 1, quoting David Meyer 1975: 61

<sup>15</sup> Buckley, Helen and Kew J., Hawley John, *The Indians and Metis of Northern Saskatchewan, A Report on Economic and Social Development*, Saskatoon: Centre for Community Studies, 1963, suggested that kinship groups were the former method of control in Indian societies prior to Indian Affairs and that the family social unit was the traditional authority. Also R. Wesley Heber in "Indians as Ethnics: Chipewyan Ethno-Adaptations," *Western Canadian Anthropologist* 6, no.1 (1989): 55-77, notes similar kinship-based social organization systems among the Chipewyans of northern Saskatchewan.

<sup>16</sup> Ballantyne Phillip, et al., *Aski-Puko: The Land Alone*, A response to the proposed hydro-electric installation at Wintego Rapids by the Cree of the Peter Ballantyne and Lac La Ronge Bands, Saskatoon: Office of the Treaty Commissioner, 1976, 5, hereinafter will be cited as the *1976 Aski-Puko study*

centralized reserve community but having summer meeting places, such as the one in Pelican Narrows, where once a year they would gather to get their Treaty annuity payments.<sup>17</sup>

It was a society that Max Weber would have described as representing the "older social structures" with highly subjective and personalized authority systems where the master made decisions based upon "personal sympathy and favor, by grace and gratitude."<sup>18</sup> In this case, however, it was not a feudal type of master-servant society, rather it was a family or kinship system usually led by a male head of the family or household. T. Kue Young explained this form of kinship political culture<sup>19</sup> as an adaptation by pre-contact societies to their harsh environment. Their small, scattered populations were not suited to a "complex, hierarchical social and political structure," and he stated, "both self-reliance and mutual cooperation were essential to survival. Values such as sharing, generosity, and hospitality were well suited to aboriginal hunting life, and they have by and large endured into the present."<sup>20</sup>

Young's description is consistent with the framework of fundamental values of non-agricultural and pre-capitalist societies as described by anthropologists Eleanor Leacock and Richard Lee which include:

1. Collective ownership of the means of production – land and resources.
2. Right of reciprocal access to resources of others through marriage ties, visiting and co-production.
3. Non-accumulation due to need for mobility.
4. Generalized reciprocity with others in need.

<sup>17</sup> Indian Affairs and Northern Development, Indian Affairs Annual Report: 1904, by S.R. Marlatt, Inspector of Indian Agencies describes Pelican Narrows as an old Hudson Bay post.

<sup>18</sup> Weber Max, "Bureaucracy," in H.H. Gerth and C. Wright Mills (Translators, Eds.): From Max Weber: Essays in Sociology, New York: Oxford University Press, 1946, 216

<sup>19</sup> Beatty Bonita, op.cit., 2, where traditional political culture refers to the shared political values and belief systems of hunting and gathering societies of northern Saskatchewan.

<sup>20</sup> Young T. Kue, Health Care and Cultural Change: The Indian Experience in the Central Subarctic, Toronto: University of Toronto Press, 1988, 14



5. Equitable access to the forces of production, meaning that everyone is taught how to make essential tools.
6. Individual ownership of tools, although lending is flexible.<sup>21</sup>

This generalization of the value systems of hunting and gathering societies is useful because it provides a structural reflection of the historical way of life of the Peter Ballantyne people and their cultural values. Within this context, we can extrapolate the nature of their traditional authority system and try to understand how power was distributed amongst the families, how relationships were organized and how decision-makers were held accountable. PBCN pre-contact history has already been thus extrapolated using the ethnographic representation of foraging societies by the 1976 Aski-Puko study, and it depicts the household as being the basic unit of production, although it may have included the extended family of close relatives depending on the time of year and availability of food resources. There was limited specialization of roles in the household except for political leadership and spiritual authority.<sup>22</sup>

Although there were divisions of labor according to gender, age and skill, leadership was flexible and directed by group consensus. Scholars suggest that the harsh environment forged cooperative networks and values of sharing, cooperation, respect and hospitality among foraging societies.<sup>23</sup> Their kinship system emphasized the development of large family networks as a means of ensuring kindness and assistance in times of need. For example, when a hunter killed a moose, the meat was

<sup>21</sup> Leacock Eleanor and Richard Lee., *op.cit.*, 8, 9

<sup>22</sup> Ballantyne Phillip, *et.al.*, *op.cit.* 5, 6

<sup>23</sup> T. Kue Young, *Health Care and Cultural Change: The Indian Experience in the Central Subarctic*, Toronto: University of Toronto Press, 1988, 14.

shared because keeping alive required a cooperative effort and it was effective as long as everyone was doing his or her part.<sup>24</sup>

Leadership authority was earned through the demonstration of various skills such as diplomacy, verbal persuasion, hunting and trapping expertise and spiritual or shamanistic abilities. According to Robert Brightman, male leaders whose authority was earned through age and foraging skills dominated families. Elders were respected for their experiential wisdom and were influential in the family by providing support through advice and teaching.<sup>25</sup> The main role of the leader was to protect the group but there was no formal means of enforcing decisions. Compliance and social order were maintained through social customs rather than written rules and laws because the households were small, self-sufficient and highly nomadic.<sup>26</sup>

Brightman also described some aspects of the communal nature of the Rock Cree traditional life in the hunting practices associated with the multi-family hunting groups during the early fur trade era. He stated that similar to other sub arctic and arctic hunter-gathering societies, reciprocity was a fundamental value practiced when it came to the distribution of foods like meat that were always shared among co resident families of the hunting group.<sup>27</sup> Likewise the Aski-Puko study described the food sharing activities of the Peter Ballantyne Cree as a systematic redistribution of

<sup>24</sup> Merasty Ron, op.cit., in *Traditional Cree Culture, Part 2: Cree Cultural Traits*, 9

<sup>25</sup> Brightman Robert E., *Grateful Prey: Rock Cree Human-Animal Relationships*, Berkeley, California: University of California, 1993, 11

<sup>26</sup> Beatty Bonita, *The Transformation of Indian Political Culture in Northern Saskatchewan*, unpublished Master's Thesis, 1996, 1, also Eleanor Leacock and Richard Lee, in *Politics and History in Band Societies*, Cambridge University Press, 1982, 8, 9 discuss the communal values of production that were developed through subsistence economic activities where people "made decisions collectively."

<sup>27</sup> Brightman Robert E., op.cit., 10

resources from richer to poorer households through the kinship structure of the community.<sup>28</sup>

Clearly the notion of traditional governance was embedded in the values and practices of the family households or kinship relationships because there was no "state" authority to determine rights and responsibilities. For instance, the concept of reciprocity or sharing among family households has been generally accepted as a traditional value of the Rock Cree as well as other hunter-gatherer societies. Eleanor Leacock and Richard Lee in their work on the politics and history in band societies, stated that "people shared food; there were no rich and poor. They made decisions collectively; some people were more influential than others, but there were no powerful chiefs. Foraging peoples worked hard, but contrary to popular stereotypes, life was not a grim battle for survival."<sup>29</sup>

The 1976 Aski-Pko study supports this egalitarian communal depiction of Cree culture where subsistence goods were communally shared in the household and expectations were placed upon individuals to contribute their share to the common good, although the notion of sharing also included other relatives outside the primary household.<sup>30</sup> James G.E. Smith further described subsistence culture as generally being based upon patrilocal hunting groups connected by bilateral cross-cousin marriage ties, and further linked into regional bands<sup>31</sup> and Robert Brightmans' portrayal of the Cree hunting groups as flexible compositions of families led by male

<sup>28</sup> Ballantyne Phillip, et.al., *Aski-Puko: The Land Alone*, op.cit. 255

<sup>29</sup> Leacock Eleanor, Richard Lee, eds., *Politics and History in Band Societies*, Cambridge University Press, : 1982, 8, 9

<sup>30</sup> Ballantyne Phillip, et al., *ibid*, 10

<sup>31</sup> James G.E. Smith, "The Western Woods Cree: Anthropological Myth and Historical Reality, 1987, an essay from Miller, et al., *The First Ones: Readings in Indian/Native Studies*, Saskatchewan Indian Federated College Press, Piapot Reserve #Q75: 1992, 88



leaders whose influence was based upon age and foraging experience also supports these views.<sup>32</sup>

Along with these ethnographic representations of traditional authority, the written and oral accounts of the early contacts between the Peter Ballantyne people and the fur traders and Indian Affairs agents provide the only means of evidence specific to PBCN history. The households with their informal and autonomous authority structures were not formally organized into larger regional groupings, so references to them as "bands" in the fur-trading journals and Indian Affairs reports were generally for the purposes of trade and Treaty-making rather than a description of their governance system.

### **Fur Trade**

Without getting into the detailed history of the fur-trade and various theories of dependency,<sup>33</sup> it is important to look at its general influence upon these traditional household systems. The Hudson Bay Company dominated the fur trade in the Churchill region by the time the adhesion to Treaty six was signed in 1889. With the merger of Montreal-based Northwest Company in 1821, the HBC was finally able to

<sup>32</sup> Brightman Robert E., *op.cit.*, 11

<sup>33</sup> Such detail can be found with fur Trade historians such as Arthur J. Ray in Indians in the Fur Trade: Their Role as Trappers, Hunters and Middlemen in the Lands Southwest of Hudson Bay, 1670-1870, Toronto: University of Toronto Press, 1974; Paul C. Thistle in Indian-European Trade Relations in the Lower Saskatchewan River Region to 1840, Winnipeg: The University of Manitoba Press, 1986; W. A. Sloan in "The Native Response to the Extension of the European Traders into the Athabasca and Mackenzie Basin, 1770-1814," The Canadian Historical Review, ix, 3, University of Toronto Press, 1979; Frank Tough, "Buying Out The Bay: Aboriginal Rights and The Economic Policies of The Department of Indian Affairs after 1870," an essay in The First Ones: Readings in Indian/Native Studies, eds., D. Miller, C. Beal, J. Demsey and R. Wesley Heber, SIFC Press, Piapot Reserve #75: 1992, 403, 404; and Jennifer S.H. Brown in Strangers in Blood: Fur Trade Families in Indian Country, Vancouver: University of British Columbia Press, 1980.

enforce the terms of the Royal Charter of 1670 granting them a trade monopoly over the northwest. The rivalry prior to that period with independent traders was intense with the trading posts competing for exclusive trade with the various Cree families of the region.

The various HBC archival journals from the Pelican Narrows post depict a rather possessive and paternalistic approach by traders to the Cree trappers as shown in this 1818 excerpt by one fur trader:

"After spending Christmas in Cumberland House...we journeyed to Pelican and met up with 3 Indians belonging (to) Mr. Kennedy and one which Mr. Connolly lays claim to, but I conceived I had as much claim as he had and more for he traded with me the last winter and in the spring as he was going to Cumberland House that rascal Frobisher met him, pillaged him of his fur and beat him, therefore its plain the Indian wishes to trade with us, but he is prevented by the Northwest merchants."<sup>34</sup>

Obviously, life was very difficult during that period. Epidemics, such as the smallpox outbreak in 1782 killed over half of the Cree population estimated at 644 persons or 92 families living in the Churchill and Nelson River regions,<sup>35</sup> and by the 19<sup>th</sup> century, the changing patterns of health and diseases such as measles, whooping cough, scarlet fever and influenza caused families to become more indebted to the trading posts for vaccinations and food supplies.<sup>36</sup> As a result, their traditional nomadic lifestyles became more sedentary and localized around trading posts.<sup>37</sup>

It has been suggested that by the time the adhesion to Treaty six was signed in 1889, the people of the LaRonge and Pelican Narrows region had become "dependent

<sup>34</sup> Ron Merasty, op.cit., quoting HBC trader John Pocock Holmes from the Pelican Lake Journal 1818-1819.

<sup>35</sup> Brightman Robert A., op.cit, 9

<sup>36</sup> T. Kue Young, op.cit.,34

<sup>37</sup> Sloan W.A., "The Native Response to the Extension of the European Traders into the Athabasca and Mackenzie Basin, 1770-1814," The Canadian Historical Review, ix, 3, University of Toronto Press, 1979, 282

upon the trade economy over which they had little control,"<sup>38</sup> and facing game depletions and declining fur prices, they wanted help from the federal government. The extent to which that dependence upon external authorities affected their own households is uncertain. It may have produced inequitable power relations in the family with the formalization of male leadership in the fur trade and lessened the need for consensus decision-making. Political scholar, Ron Bourgeault, suggests that "the social relations of production (families) were altered and at the same reproduced, for the purposes of creating the commodity production of fur," thus changing their communal societies to more individualistic nuclear family units.<sup>39</sup>

The practice of appointing influential males as formal political representatives for negotiating group relations was evident in both the fur trade and Treaty process. The HBC practice of appointing "trading captains" was an effort to enhance the status and influence of the influential males with their families and thus garner their exclusive trade. The trading captains were offered perks such as larger lines of advanced credit in the fall with the idea that they would pay it back with their spring catches.<sup>40</sup> The signing of the treaties required the appointment of chiefs and councilors and they were given special gifts of uniforms, flags, silver medals, and small annual salaries of \$25 and \$15 to chiefs and councilors respectively to symbolize their leadership and duty to see that their bands complied with the treaties.<sup>41</sup>

### **The Federal Government & Its Indian Policies**

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<sup>38</sup> Ballantyne Phillip, et al., op.cit. 15

<sup>39</sup> Denis McLeod, From Exploitation to Marginalization: The Aboriginals of Northern Saskatchewan in Relation to the National and International Political Economy, Regina: University of Regina, Unpublished Masters Thesis, 1991, 37, quoting Ron Bourgeault

<sup>40</sup> Ray Arthur, op.cit., 137

<sup>41</sup> Morris Alexander, The Treaties of Canada with the Indians of Manitoba and the North-West Territories, Toronto: Coles Publishing Company, 1979, 286



The consistent theme in the Indian Affairs reports to transform the Indian people from the "untutored state" of their communal traditional life and to instill the "spirit of individuality" by replacing their hereditary leadership with elected chiefs, councilors or headmen suggests that the traditional governance systems were still strong enough to cause concern with the Indian Affairs department who reported that the hereditary systems were "retarding" their attempts to teach the values of individuality over communal or familial leadership. To change that, the department's policy was to replace the kinship systems of political authority with elected leaders in the same way as municipal councils in "white" communities and it eventually became law with the passing of the "Advancement Act."<sup>42</sup>

The influence of the federal state came to the north through the treaties in 1889, but the administration of the region was disorganized and its control negligible and limited to treaty payment events, until the post world war 2 development in the north. On the national scene, with the passing of the 1867 British North America Act, the Crown had given constitutional jurisdiction and authority to the federal government to legislate the affairs of "Indians and lands reserved for Indians"<sup>43</sup> through section 91(24). The roots of Indian administration, however, date back to the late 17<sup>th</sup> century when the thirteen colonies appointed Indian Commissioners to regulate the fur trade and liquor traffic. After undergoing many departmental and ministerial portfolios, from the secretary of state to the Department

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<sup>42</sup> Indian Affairs and Northern Development, Indian Affairs Annual Report: 1897, by JAS.A. Smart, Deputy Supt.General of Indian Affairs.

<sup>43</sup> Bradford W. Morse, Aboriginal Peoples and the Law: Indian, Metis and Inuit Rights in Canada, Ottawa: Carleton University Press, 1985, 156

of the Interior in 1873, it was not until 1967 that a separate Department of Indian Affairs and Northern Development was created.<sup>44</sup>

In 1876, the Indian Act was passed consolidating and confirming all pre-confederation legislation and policy directives, and giving sweeping powers of a "total institution"<sup>45</sup> to the Indian department and administrators and agents. By that time, it had evolved into a highly centralized bureaucracy implementing externally driven policies over essentially powerless local political institutions.<sup>46</sup> The goals behind Indian policy were protection, assimilation, Christianity, reserves and self-sufficiency, enfranchisement and the signing of Treaties.<sup>47</sup> The impact to traditional governance was that it effectively replaced the systems of authority and leadership under the control of Indian agents.<sup>48</sup>

With assimilation as a priority policy, the treaty process was designed to extinguish Indian title to land in exchange for reserves, cash payments and other provisions, and to provide transitional protection of the Indian people who they believed were facing eventual extinction. Most of the prairie treaties were signed between 1871 and 1910 except for the northern regions where adhesions to existing treaties were later signed. In 1889, the Crees from the La Ronge region signed an adhesion to Treaty 6 that had been signed by Commissioner Alexander Morris at Fort

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<sup>44</sup> Titley Brian E., A Narrow Vision: Duncan Campbell Scott And The Administration of Indian Affairs In Canada, Vancouver: University of British Columbia Press, 1986, 8

<sup>45</sup> Ponting Rick J., Roger Gibbins, Andrew J. Siggner, Out of Irrelevance: A Socio-Political Introduction to Indian Affairs in Canada, Toronto: Butterworth and Company Ltd., 1980, 9, 10

<sup>46</sup> Armitage Andrew, "Comparing Aboriginal Policies: The Colonial Legacy," in John H. Hylton, ed., Aboriginal Self-Government in Canada: Current Trends and Issues, Saskatoon: Purich Publishing Ltd., 70

<sup>47</sup> Ponting et.al., *ibid*, 16

<sup>48</sup> Ponting et.al., *ibid*, 11

Carlton and Fort Pitt in 1876, and in 1898, the people from the Pelican Narrows region under Peter Ballantyne adhered to Treaty 6 as well.<sup>49</sup>

According to notes and reports taken by Commissioner Colonel A.G. Irvine and Roger Goulet during the adhesion to the Treaty 6 treaty signing in February 1889 and descriptions of the process by the Archdeacon John A. McKay of the Anglican Church, who did the Cree translations for both Treaty 6 in 1876 and its adhesion, two bands were created, 278 people under Chief James Roberts under the Lac La Ronge Band and 98 people under Chief William Charles of Montreal Lake.<sup>50</sup> The chiefs were selected by those present, mostly adult males and teenaged boys, at the signing through informal polls and ratified by the approval of the Indian Commissioner.<sup>51</sup> The seemingly easy acceptance of state authority at the time appeared to be a matter of survival. Having heard that the Canadian government was signing treaties, setting aside reserve lands and promising help to those in need, the leaders wanted the same for their families considering they were fearful of starvation due to the depletion of fur-bearing animals, scarcity of game for food and the reduction in fur prices.<sup>52</sup>

The Treaty 6 adhesions contained the same general terms for land and provisions, except for the addition of the medicine chest clause, as those in eastern Canada so little negotiation was possible.<sup>53</sup> The provisions in the Treaties were designed to support the assimilation policy of the federal government to transform traditional societies into what the deputy superintendent of Indian Affairs Hayter

<sup>49</sup> Beatty Bonita, op.cit., 61

<sup>50</sup> <sup>50</sup> Indian Affairs Northern Development, Indian Affairs Annual Report, 1889, ibid

<sup>51</sup> Indian Affairs Northern Development, Indian Affairs Annual Report: 1889

<sup>52</sup> Merasty Ron, essay on Adhesion to Treaty Six By The James Roberts and William Charles Bands in 1889, 4, references Reverend Trivett's letter describing the situation, also the Department of Indian Affairs Report: 1890 describes similar depletion of fish, large game and fur-bearing animals in the northern regions of Manitoba and Keewatin.

<sup>53</sup> Phillip Ballantyne et.al, op.cit., 49



Reed referred to as "competent agriculturalists, ranchers or mechanics."<sup>54</sup> The provisions included: 160 acres per family of five; annuity; schools on reserves; prohibition from alcohol on reserve; agricultural implements and livestock; other clothing and equipment like fishing twine and traps; special gifts of uniforms, flags, silver medals and small annual salaries of \$25 and \$15 to chiefs and councilors respectively and provisions for medical and famine relief.<sup>55</sup>

The impracticality of trying to force a standard agricultural model in the north became clear at the 1889 signing when chiefs James Roberts and William Charles expressed concern over the provision of agricultural products such as cattle, horses, pigs, ploughs, harness and wagons due to the difficulty of transporting them by canoe. It had taken them two days to travel from the La Ronge area to the Montreal Lake to attend the signing. The chiefs preferred items such as ammunition, tents, stoves, dog harnesses and twine for nets. They requested farm instructors to teach them farming and since they were already familiar with gardening, they wanted spring seed potatoes. They also requested medicines, schools, and clothing for the old and helpless people and for the treaty payments to be paid in the middle of September so it would not interfere with their hunting. Reserve selections were left for later.<sup>56</sup>

#### **Peter Ballantyne Entry into Treaty**

Peter Ballantyne, the first chief of the current PBCN, was excluded from this 1889 treaty process due to administrative technicalities, but he eventually signed on

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<sup>54</sup> Indian Affairs Annual Report, 1893, op.cit.

<sup>55</sup> Beatty Bonita, op.cit., 61

<sup>56</sup> Indian Affairs Reports: 1889, op.cit.

as part of the James Roberts Band along with his family at Potato Lake, near La Ronge in 1894.<sup>57</sup> Treaty paymaster reports described the events at the time:

"The Ballendine family went to Potatoe River last year to enter Treaty, they were refused payment for the reason that they were outside of ceded territory, these men, Peter, Noah, Thomas, et al., ask me to say in reply that they have as much right to enter Treaty as now being paid at Potatoe River for the following reasons:... They were all born and brought up on Lac La Ronge. Right up to the present time the hunting grounds of Peter and his sons are within ceded Territory, on the south east of Bear Mountains towards Candle Lake,..."<sup>58</sup>

Although the family resided in hunting territories within the ceded area, they purchased supplies from the Hudson Bay Post at Pelican Narrows instead of Lac La Ronge and were thus deemed to belong to Pelican Narrows, which was outside the ceded territory. In 1895, 42 members of the Ballantyne family were approved to enter Treaty as part of the James Roberts Band.<sup>59</sup> Five years later, in 1900, because of regional disparities such as distance and different religions – James Roberts was Anglican and people from Pelican Narrows predominantly Roman Catholic<sup>60</sup> - the people from Pelican Narrows formed a separate band. Peter Ballantyne was appointed chief through an informal poll and remained so until his death in 1917, at which time Cornelius Bear was appointed.<sup>61</sup>

As far as his personal life went, any accounts of Chief Peter Ballantyne are vague and subject to different interpretations because of the references to many "Peter Ballantyne's" in the trading journals and missionary records. One version suggests

<sup>57</sup> Office of the Treaty Commissioner, Peter Ballantyne Band-Historical Notes: (RG 10 Black 56622, vol.3815), Saskatoon: Office of the Treaty Commissioner, 1972

<sup>58</sup> Office of The Treaty Commissioner, Peter Ballantyne Band-Historical Notes: (RG 10 Black 56622, vol. 3815), Saskatoon: Office of the Treaty Commissioner, 1972

<sup>59</sup> Ron Merasty's notes, Peter Ballantyne Members Enter Treaty, 11, 12, referenced correspondence dated August 20, 1894 from Anglican missionary, Archdeacon Rod McLennan of Stanley mission to the Indian Agent at Potatoe River supporting the Ballantyne claim.

<sup>60</sup> Indian Affairs and Northern Development, Indian Affairs Annual Report: 1911, lists the Peter Ballendine population at 541 registered members, 124 Anglican and 417 Roman Catholic

<sup>61</sup> Beatty Bonita, op.cit., 61

that he spoke the "y" dialect which implies a plains Cree origin, and that he was abandoned when he was about 12 years old and was found at a "Acitniwi"<sup>62</sup> lake by the Ballantyne family who trapped in the region and was adopted by them, but this may have referred to his father, given that written accounts such as the Anglican baptismal records list his home as being La Ronge as described by the Indian agents.

According to descriptions by the Indian Agent, Joseph Courtney in 1906, the Peter Ballantyne Band were all hunters with no permanent place of residence and not located on reserves, but rather "scattered over a very large extent of country, and from appearances seem to make a better living than most of their brethren to the south. They meet once a year at Pelican to receive their annuities."<sup>63</sup> By 1911, the population of the band was 541, 124 Anglican and 417 Roman Catholic.<sup>64</sup>

The descriptions of the housing that people had in the 1920's included tents in the summer, and well-constructed log houses in the winter made of "log walls, roofs made of poles and covered with mud, floor of bark and brush, open fireplaces and one or two rooms," but these had poor ventilation thus leading to poor health conditions.<sup>65</sup> Heavy mortality rates were recorded due to an influenza epidemic, viral bronchial pneumonia and tuberculosis. The people were generally self-supporting with hunting and trapping as the main sources of income. It was noted that the people were taking on more of the "white man's implements and dress- birch bark canoes replaced by cedar or basswood canoes, sewing machines, gramophones, guns," and rarely dressed

<sup>62</sup> Ron Merasty, *ibid*, 1, states that the Cree translation means "the lake of a person of a different origin."

<sup>63</sup> *Indian Affairs Annual Report: 1906*, *op.cit.*

<sup>64</sup> *Indian Affairs Annual Report: 1911*, *ibid.*

<sup>65</sup> *Indian Affairs Annual Report: 1920*, *ibid.*



in their "romanticized versions of hunters dressed in buckskins, beadwork and feathers," except for special ceremonies.<sup>66</sup>

By 1926 to 1930, serious health problems like TB and poor economic conditions were being recorded in the north arising from the depletion of fur and game resources and the over trapping practices of "white trappers moving north", using "poison" and other means, then moving out of the depleted areas, "leaving the original native population in a state of destitution."<sup>67</sup> The effect was to push the Indian trappers further north away from their family trap lines, some taking their families with them, thus creating financial hardships for them because they would have to buy enough goods to make the winter and few could get sufficient credit to outfit themselves. While there were federal game laws in place, there was limited policing structure to enforce them in the north. Various Indian agents expressed the need for game conservation and advocated for the Indian trappers fearing that the loss of their livelihood would make them become dependent:

"Indian families, in most cases, are permanent residents, and their hunting grounds are recognized among themselves, and handed down from one generation to another, whereas white trappers are frequently of the itinerant class, whose practice is to trap out an area and then move elsewhere."<sup>68</sup>

The department granted special hunting privileges and the granting of free trapping licenses to hunters as a way of monitoring their fur harvest. With the passing of the 1930 Natural Resources Transfer Agreement transferring the jurisdiction over land and natural resources to the provinces of Saskatchewan and Manitoba, except for reserves, special provisions were set aside for Indians to hunt, fish and trap for food at

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<sup>66</sup> Indian Affairs Annual Report: 1920, *ibid.*

<sup>67</sup> Indian Affairs Annual Report: 1926, *ibid.*

<sup>68</sup> Indian Affairs Annual Report: 1929, *ibid.*

all seasons of the year on all unoccupied Crown lands and in private lands to which they allowed a right of access.<sup>69</sup> As well, there was provision for the creation of future reserves where the province, "at the request of the Superintendent of Indian Affairs, would set aside, out of unoccupied Crown lands, and lands selected and agreed upon for Treaty Land Entitlement by the federal government."<sup>70</sup> It would take 62 years for the Peter Ballantyne Band to settle their reserve claims through the Saskatchewan Treaty Land Entitlement Framework Agreement in 1992, along with 22 other bands.<sup>71</sup>

### **The Provincial Government, Churches and Post War Developments**

Unlike the south, the encroachment of the state upon the Peter Ballantyne band was slower and did not really develop until after the second world war because of the isolation, and what political writer, Murray Dobbin referred to as the "lack of capital penetration."<sup>72</sup> Northern people had developed a unique society distinct from the rest of the province, but that changed with the influence of the modernization and integration policies of the CCF government from 1945 to 1964. The policies were administered through the department of National Resources and Industrial Development (DNR), a department that has been described as the instrument or "engine" of economic socialism and colonialism.<sup>73</sup>

<sup>69</sup> McNeil Kent, Indian Hunting, Trapping and Fishing Rights in the Prairie Provinces of Canada, Saskatoon: University of Saskatchewan Native Law Centre, 1983, 20

<sup>70</sup> Indian Affairs Annual Report: 1929, op.cit.

<sup>71</sup> Indian and Northern Affairs Canada, Saskatchewan Treaty Land Entitlement: An Overview, Regina: DIAND Saskatchewan Region, 1

<sup>72</sup> Dobbin Murray, "Prairie Colonialism: The CCF in Northern Saskatchewan, 1944-1964," Ottawa: Studies in Political Economy: A Socialist Review, Number 16, 1985, 11

<sup>73</sup> Quiring David M., Battling Priests, Bootleggers and Fur Sharks: CCF Colonialism in Northern Saskatchewan, A Dissertation Submitted to the College of Graduate Studies and Research in Partial Fulfilment of the Requirements for the Degree of Doctor of Philosophy in the Department of History, University of Saskatchewan, Saskatoon: Spring 2002, 3, 4

The situation of the Treaty Indians in the north cut across federal and provincial jurisdictions, particularly in the area of housing, medical care and welfare services. On the federal side, the Indian Affairs department dealt exclusively with Indians registered as status Indians as defined under the Indian Act and any provision of services had to be reserve-based. For Peter Ballantyne, with the creation of only five reserves by 1940, most people were still off-reserve in their various trapping areas, and whatever services were offered on-reserve were at best, peripheral and itinerant, and under the control of external Indian Affairs personnel who hired priests, trading post managers, RCMP to deliver rations and medical help, and those without reserves came under provincial control.

The Roman Catholic and Anglican Churches, for example, provided much of the medical and education services in the north prior to 1945 through agreements with the Indian Affairs department, and were thus able to forge strong historical ties and influence amongst the families they converted. For example, in 1889, during the treaty ceremonies, the people of the La Ronge region were described as "a very intelligent, respectable and religious class of Indians" indicating their conversion.<sup>74</sup> Political divisions along religious and geographical lines were also evident in the evolution of the Peter Ballantyne band. The first Chief, Peter Ballantyne was Anglican and when he passed away in 1917, Cornelius White Bear who was Roman Catholic from the Sandy Bay region replaced him. The people from Pelican Narrows protested with each religious faction wanting their own chief, but the Indian department denied their request indicating that the Indian Act applied to all Indians

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<sup>74</sup> Indian Affairs Annual Report: 1889, ibid



regardless of belief.<sup>75</sup> While the extent of the prevailing influence of these religious divisions is uncertain today, they have played some part in the selection of chiefs, most of who continue to be from the more dominant Roman Catholic population in Pelican Narrows.

In the early 1920's, the residential school policy was being enforced and administered by either the Roman Catholic or Anglican churches, and many children from the Pelican, Southend and Pukatawagan areas were sent away to places like the Guy Hill Indian Residential School in Sturgeon Landing.<sup>76</sup> In Pelican Narrows, separate day schools were set up for the Roman Catholic and Anglican children,<sup>77</sup> and this continued until the mid-1970s when the Peter Ballantyne Band took over and set up a public school for all children to attend, regardless of their legal and religious status.

While the centralization policies of both federal and provincial governments to bring "all aboriginals who lived in the bush into settlements"<sup>78</sup> had many positive community development initiatives such as housing, medical clinics and schools, during a time of scarcity and sickness, they also brought in increasing control by government personnel who managed and delivered the services. The nomadic way of life changed as people starting settling into semi-permanent communities where services, however limited, were available. By the 1930s, road construction programs cost-shared between the federal-provincial governments under the Unemployment

<sup>75</sup> Merasty Ron, *Elections*, op.cit. 2

<sup>76</sup> Beatty Bonita, op.cit., 65

<sup>77</sup> Desmonie May, *History of Pelican Narrows, Opawikoschikun*, Northern Education Program, College of Education, University of Saskatchewan, 46

<sup>78</sup> *ibid*, 49

and Agricultural Assistance Act opened up various isolated regions in the north including the road from Montreal Lake to La Ronge.<sup>79</sup>

The outbreaks of epidemics like influenza, whooping cough, scarlet fever and TB were causing many deaths and control measures by the Indian Affairs department included the hiring of a medical superintendent located in Prince Albert.<sup>80</sup> With limited communications and infrastructure apart from several residential schools and nursing stations, access to services was limited to air and water transportation because there were no roads connecting the north to the south, nor the communities to each other. But the change upon the families themselves was gradual and it was not until they were unable to feed their families due to the depletion of fur and game that they started depending upon government aid.

The Pelican Post journals from 1896 to 1940, despite the narrow perspectives of the HBC personnel, provide a reflection of the kind of itinerant services being provided by the Indian Affairs department and also the socio-economic situation of the time with stories of daily incidents with the people of region. These included accounts of Anglican and Roman Catholic priests coming from La Ronge and Cumberland to hold services, perform marriages with people coming in by canoes to attend services; people traveling and carrying supplies to Southend Reindeer by York boats; people traveling long distances from the trap lines to come and sell their furs, often by canoe, dog teams or foot depending on the season; Easter, Christmas and Treaty day celebrations with people coming together from far distances; medical provisions being sent by plane and the sick getting flown to either the Pas or Flin Flon

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<sup>79</sup> Ballantyne Phillip, et.al., op.cit., 145

<sup>80</sup> Indian Affairs Reports: 1945, op.cit.

for treatment; the RCMP holding courts for offences like making home brew and enforcing game laws upon trappers and government policies, such as sending children to the residential school in Sturgeon Landing; complaints against the chief for neglecting his duties; stories of fur and game shortages by trappers with increasing requests for food and supply rations, and criticisms of an "overindulgent" Indian agent spoiling the people much to the "disgust" of the priest charged with distributing rations to some seventy people.<sup>81</sup>

The CCF policy with respect to Indians was also based upon their integration or assimilation into the general society with all the rights and benefits of all other Canadians. The idea was to bring Indian people under provincial jurisdiction so they could access better services, get the franchise to vote in provincial elections, and gain equal liquor rights. However, the jurisdictional issues remained unsolved and it was not until 1960 that the provincial franchise and liquor rights were passed in the legislature along with the enabling changes to the Indian Act at the federal level.<sup>82</sup> During this period, the various CCF initiatives were geared to individual needs under a larger provincial umbrella as opposed to the larger political goals held by the emerging Indian organizations in the province, who were pushing for collective Indian rights to self government as well as improved social conditions for Indian people.<sup>83</sup> The Indians of the north were generally left out of the larger political scene

<sup>81</sup> Merasty Ron, draft summary of *The Pelican Post Journals: 1896-1940*, op.cit., 1-21.

<sup>82</sup> Pitsula James M., "Saskatchewan CCF Government and Treaty Indians, 1944-64," in *The Canadian Historical Review*, LXXV, 1, 1994, 24-38

<sup>83</sup> Government of Saskatchewan, *Joint Committee of the Senate and the House of Commons on Indian Affairs*, Ottawa, Ontario: 1960, 90, The province funded the organizing efforts of an Indian Advisory Committee made up of nine Indian agencies to provide advice on various issues in 1958. This committee was the forerunner to the current Federation of Saskatchewan Indian Nations, FSIN.



until the 1960s and therefore had to adapt to the state developments occurring around them.

Modernization came in the form of setting up and moving people into organized settlements and building infrastructures such as schools, hospitals, stores and fish plants.<sup>84</sup> Aspects of economic socialism were introduced with the regulation and control of northern resource development through Crown corporations and marketing boards. Although under federal jurisdiction, Indian people still had to deal with issues under provincial jurisdiction, especially in areas that affected their livelihoods such as regulatory game laws, trapping and commercial fishing regulations. In 1946, a joint federal and provincial agreement established the whole north as one fur conservation area divided into 99 fur blocks with family trap lines in the blocks being further divided and licensed by zones. Advisory councils, elected by the various zone trappers, were set up in each block to help manage the trapping program.<sup>85</sup> This method of citizen participation in government decision-making through advisory councils became the trend in northern development. By 1952, community commercial fishing and trapping cooperatives were organized largely by Indian and Metis activists hired by the provincial department of Natural Resources as social development field workers. Peter C. Tompkins managed a radio information program advising people how to apply for various government services like welfare. Jim Brady and Malcolm Norris helped set up informal community councils, producer cooperatives and prospector training programs.<sup>86</sup>

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<sup>84</sup> Quiring David M., op.cit., 49

<sup>85</sup> Ballantyne Phillip., et.al., *Aski-Puko*, op.cit., 205

<sup>86</sup> Beatty Bonita, op. cit. 84

With their increasingly peripheral advisory involvement in government decisions in the 1960s, and limited employment opportunities in the mining and hydro-development industries, many became dependent upon social programs that, as noted by one Indian Affairs official, they considered part of their entitlements under Treaty:

It is evident that the more vocal Indians are endeavoring to base their acceptance of relief on the assumption that it is an entitlement. They pointed out that their ancestors merely ceded the top six inches of the soil, and this did not include the minerals, oil, gas, coal, uranium, etc., when completing treaty agreements in the 1870's.<sup>87</sup>

Faced with increasing costs in social programs, the federal and provincial governments attached treaty and non-treaty distinctions to programs and services, thus causing differentiation in treatment and status to aboriginal families, many of whom were denied Indian status by the terms of the Indian Act. This problem was reflected in a submission by the provincial government to the joint committee on Indian Affairs in 1960:

"In northern Saskatchewan, one of the effects of jurisdictional definitions and administrative practices based on status has been the creation of hostility between Indians and Metis. Here the problem arises because differentiation in treatment and status is accorded culturally similar people...the non-commercial sawmill programs run by both the federal and provincial governments in the north are an example...A wage is paid to a Metis sawyer to run the provincially operated mills. Metis who want to use a provincial mill haul their own logs and pay for the services of the mill. The federally owned mills are operated by Whites and Indians who wish to use them are paid in rations to haul logs and are allowed use of the mills free."<sup>88</sup>

Prior to the enforcement of the terms of the Indian Act, the question of belonging and political representation to a group was through family households where citizenship

<sup>87</sup> Phillip Ballantyne, et.al., op.cit. 187

<sup>88</sup> Government of Saskatchewan, Joint Committee of the Senate and The House of Commons on Indian Affairs, Ottawa: Ontario: 1960, 3

and membership were synonymous. Changes to the traditional system occurred with the imposition of political representation and membership through elections and band councils in the early 1900s. The determination of community membership and identity was legislatively restricted to those registered as "Indians" under the Indian Act or who were entitled to be registered, regardless of blood relationships.<sup>89</sup> Indian status became a matter of socio-economic consequence with reserve development because it determined access to federal services and benefits such as free housing, education, medical coverage, tax exemptions and hunting and fishing privileges throughout the year.

#### **Contemporary PBCN Band Governance & Political Culture**

The political changes in the national scene for Indian people began affecting the north in the 1970 – 1990 era. Ponting and Gibbins described these national changes in terms of growth in Indian political advocacy, increased jurisdictional complexity, the weakening of colonialism, the emergence of new forms of administration with Indian bureaucracies and the shift by the Department of Indian Affairs to a more subtle type of "socio-fiscal control over Indians" by an increasingly technocratic Indian Affairs bureaucracy.<sup>90</sup> The political evolution and administrative capacity of the Peter Ballantyne Band during this period was influenced by two political systems, namely developments in reserve-based band administration and off-reserve municipal administration. With the organization of power attached to formal offices or various

<sup>89</sup> Warry Wayne, Unfinished Dreams: Community Healing and The Reality of Aboriginal Self-Government, Toronto: University of Toronto Press Inc., 1998, 230, 231

<sup>90</sup> Ponting Rick J., et.al, 1980, op.cit., 313-316



positions of "authority hierarchy,"<sup>91</sup> the electoral system where leaders were selected by majority vote replaced the traditional kinship methods resulting in the political domination by those with large families.<sup>92</sup> As of 1951, women were also allowed to vote and band councils were given limited powers to make community by-laws similar to those given to rural municipalities,<sup>93</sup> such as good order, hygiene, public works, zoning, game preservation, proper expenditure of band funds, and other local matters.<sup>94</sup>

While Band leaders remained subordinate to the approval processes of the Indian Affairs department, their power and influence over community members grew in conjunction to their takeover of government programs and services. As early as 1960, Indian Affairs policy promoted and facilitated local administration, community development and leadership training upon reserves. Band administrations were being encouraged to participate in the management of welfare assistance, community planning and economic development. Through the use of committees as training grounds for program governance, the assumption was that they would develop into "typical governing boards, like school boards" and would assist in the administration of their own schools.<sup>95</sup> Since the 1969 rejection by Indian groups across Canada of the federal government's White Paper Policy which proposed to repeal the Indian Act, dismantle the Indian Affairs Department and do away with the special rights of

<sup>91</sup> Boldt Menno, *Surviving as Indians: The Challenge of Self-government*, Toronto: University of Toronto Press, 1993, 118, 119 where he discusses traditional leadership characteristics as communal and kinship oriented with decisions reached by dialectic consensus, or 'town-hall' type meetings.

<sup>92</sup> Ibid, 123, Boldt suggests that traditional system has now been replaced by a ruling-class system with the leadership being the indigenous ruling class.

<sup>93</sup> *Indian Affairs Annual Report: 1951*, op.cit.

<sup>94</sup> *Indian Affairs Annual Report 1958*

<sup>95</sup> *Indian Affairs Annual Report: 1962*

Indian people, there was an increased "conscious" shift by the department to turn over more control to Band administrations.<sup>96</sup>

With changes to the national policies towards transfer of services, such as education in 1972, the challenges facing northern Band administrations were to deal with a declining traditional economy and a rising demographic trend for the region as a whole towards unemployment and increasing dependence on social programs by a rapidly growing young population supported largely by welfare income. In 1971, 34% of the northern population, estimated between 22,000 and 28000, was less than 10 years of age compared to 10% in the province, and 57 % were less than 20 years of age. Northern income was estimated close to \$20 million with traditional industries like trapping and fishing making up only 13.1 % of the total income, with the rest consisting of 31.5% mining, 24.5% government and 16.9% welfare.<sup>97</sup> Other supplemental sources of income came from national income-subsidy programs such as family allowances, pensions, unemployment insurance, and off-reserve access to provincial social assistance and health services.

The period, 1971-1994, has been described as the marginalization of aboriginal people in northern resource developments with the mining and forestry industry benefits going to industrial towns like Uranium City, La Ronge and Creighton, and very little trickling down to aboriginal communities and reserves in the form of employment and infrastructure development.<sup>98</sup> In spite of this trend, however, the

<sup>96</sup> Indian Affairs Annual Report: 1973

<sup>97</sup> Myers Timothy, Five Years After: A Review of the Department of Northern Saskatchewan's First Five Years, La Ronge, Saskatchewan: Extension Services Branch, Department of Northern Saskatchewan, 1977, 15

<sup>98</sup> McLeod Denis, From Exploitation to Marginalization: The Aboriginals of Northern Saskatchewan in Relation to the National and International Political Economy, Regina, Saskatchewan: Unpublished thesis, University of Regina, 1991, 115, also in Timothy Myers report, Five Years After, op.cit., 15

settlement creation, community development and other social engineering efforts started by the CCF in 1945 had by and large succeeded in centralizing services around organized settlements. Further developments were pursued with the creation of a specialized northern department in 1972. The department's budget grew to \$58 million by 1977, with much of the expenditures geared to the development of local governments and infrastructure. Municipal local government authorities were set up in 37 non-reserve communities through per capita funding formulas and grants amounting to over \$1.7 million. Others included the creation of various economic development incentives for business, recreational facility grants were provided to build skating rinks, over 900 public housing units were built through low-income subsidy programs, highway construction opened up the isolation of remote communities, education and medical facilities were set up, seven communities received sewer and water, and electrification and telephone services came to most communities by the mid 1970s.<sup>99</sup>

By 1994, the northern population was estimated at 34,000 with 53% or 18,000 being Treaty Indians. The estimated PBCN population in 1990 was 4934 with 2448 living on reserve and over half off reserve in municipal communities due to complications with unsettled land claims.<sup>100</sup> Nearly 50% of the northern population was under 20 years of age, with 32% being school-age children. Elders (over 65) made up about 4% with the employable age group (20-64) making up 48% of the population. The high growth rate among the Treaty Indian population was attributed to several factors such as the high birth rate among the young population and the

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<sup>99</sup> Myers Timothy, *op.cit.*, 26

<sup>100</sup> Indian Affairs Annual Report: 1990



changes to the Indian Act in 1985 which allowed many non-treaty Indians to gain or regain their Indian status, and in most cases, gain their band membership.

While population growths could be positive indicators of improved lifestyles, the demographic profile of the north was resembling population pyramids typical of underdeveloped countries where the majority young population form the wide base and the elderly, the narrow top, as opposed to the developed countries, where there is more of even distribution among the age groups. Even with improvements to life expectancy, poor countries tend to continue experiencing high birth rates thus widening the pyramid base and leading to even further predictions of rapid growth and increased economic and social costs.<sup>101</sup>

Along with the population growth, there was also increased economic hardship as reflected in various northern income and labor force reports that estimated close to 90% unemployment in the communities and reserves.<sup>102</sup> In terms of family incomes on reserves, it was estimated that over 42% came from welfare with over \$10 million per year administered by the northern bands.<sup>103</sup> Unemployment insurance coverage supplemented the seasonal and declining profitability of the trapping and commercial fishing industries due to various pressures including global animal rights activism and market regulation systems set by the European Economic Community banning the export of certain wildlife species harvested through leg hold traps. From 1981-1991, for example, the number of trappers declined by 25% from 3000-2300 license

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<sup>101</sup> Population Reference Bureau, Human Population: Fundamentals of Growth, Three Patterns of Population Change, 2004, in [www.prb.org/Content/NavigationMenu/PRB/Educators/HumanPopulation/Change/...](http://www.prb.org/Content/NavigationMenu/PRB/Educators/HumanPopulation/Change/...)

<sup>102</sup> Northern Education Services Branch, et.al., Northern Saskatchewan Planning Profile, March 1994, La Ronge, Saskatchewan: 1994, 10

<sup>103</sup> *ibid*, 8

holders. In 1987, 231,636 pelts were harvested with a cash value of nearly \$2.5 million, and by 1991, only 48,803 pelts were taken at \$0.5 million.<sup>104</sup>

Faced with a declining traditional economy and lack of a sustainable job market, the northern region was essentially under the governance of the welfare state due in part to "the continual expansion of the role of government in welfare since World War II,"<sup>105</sup> and growing dependency upon the social service programs offered by all levels of government. Individuals became less able to support their needy relatives and traditional institutions such as the kinship households and later the job market, were no longer capable of meeting community needs. The response by both the First Nations, including Peter Ballantyne, to improve their social and economic conditions was through increased control over government programs within the context of their treaties, and the response by the department of Indian Affairs was facilitate this process through various devolutionary policies.<sup>106</sup>

In spite of the heavy government influence over their political and economic systems, it has been suggested by some that traditional values such as mutual cooperation and sharing have endured, albeit to a lesser extent, in community practices such as food sharing among immediate household relatives, an attribute that Marshall Sahlins described as a delicate barometer on the quality of social relations.<sup>107</sup> The 1976 Aski-Puko study on the domestic distribution patterns of forty households in four of the Peter Ballantyne and La Ronge communities, observed that:

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<sup>104</sup> *ibid*, 50

<sup>105</sup> Hawthorn, H. B. ed., *A Survey of the Contemporary Indians of Canada: A Report on Economic, Political, Educational Needs and Policies*, Ottawa: Indian Affairs Branch, Vol.1, Oct. 1966, 313

<sup>106</sup> *Indian Affairs Annual Report: 1980*

<sup>107</sup> Sahlins Marshall, *Stone Age Economics*, New York: Aldine Publishing Company, 1972, 170

"...net donors made their most substantial donations to structurally close kin-parents, siblings, grandparents, etc. Few gifts were made to distant kin and none are recorded for non-kin. Net receivers had gifts from a broader range of kin, but the largest gifts came from structurally close kin. It is concluded that an important aspect of the local Cree economy is the systematic redistribution of resources from well-to-do to less well-to-do households, with the mechanism of redistribution being the kinship structure of the community."<sup>108</sup>

Others suggest a decline in the sharing practices and attribute these to a decline or fragmentation in the traditional Indian family structures that had the ability to provide support, security, identity and encouragement.<sup>109</sup> A northern elder observed that values based upon individualism and competition were replacing values of sharing:

"The kind of people we were up north was: if you or someone needs something, cook or give it to you. If people need help or are suffering or are old, we just try to help them all we can. People don't understand the basics of sharing – that to share is not doing a favor and does not need to be returned, and also that you don't pay for what is given to you. People shared their hunt and catch before. Today they sell the surplus...it appears that the only thing you share is alcohol...It is not our way to be competitive. We share...it bothers me if the children learn to be competitive and not learn how to share."<sup>110</sup>

Various studies on northern social and health trends indicated a consistent increase in alcohol, drugs and other substance abuse problems in most communities, including those in Peter Ballantyne.<sup>111</sup> The manifestation in various forms of neglect,

<sup>108</sup> Ballantyne Phillip, op.cit.,265; also T. Kue Young, 1988, 14 attributed the survival of sharing values to the hunting lifestyle and small populations. More recently, Tobias Terry N., and James J. Kay, in "The Bush Harvest in Pinehouse, Saskatchewan, Canada," Arctic Vol.47 No 3 (September 1994) 207-221, found in their 1993 harvest survey in the northern community of Pinehouse that the "bush harvest" (income in kind & commodities) accounted for 1/3 of total village income and suggested that land resources and kinship distribution systems still significantly contributed to the northern economy.

<sup>109</sup> National Native Association of Treatment Directors, Intervention In the Spirit of The Family: Native Alcohol & Drug Counsellor's Family Systems Treatment Handbook, Calgary, Alberta: 1989, 5

<sup>110</sup> Poelzer Dolores T., Irene A.Poelzer, In Our Own Words: Northern Saskatchewan Metis Women Speak Out, Saskatoon: Lindenblatt and Hamonic Publishing Inc., 1986, 5

<sup>111</sup> Peter Ballantyne Cree Nation, Community Health Care Plan, Prince Albert, Saskatchewan: Jan. 1995, 5



abuse, loss of parenting skills and generally poor health conditions<sup>112</sup> seemed to confirm that at the very least, the traditional kinship structures were not as strong as before, especially in cases of chronic substance abuse where families are forced to adapt in other ways to get help, including a greater reliance upon government funded intervention programs. In 1981-82, the federal government funded the Native Alcohol and Drug Abuse Program focusing on treatment, prevention, training and research to deal with the problems on reserves. However, in spite of these efforts, 1989 trends still continued to show high abuse levels among the adolescence age group to 60 years of age, after which they seemed to level off or declined.<sup>113</sup>

The extent to which the decline in the traditional kinship values affected the development of the Peter Ballantyne political system is debatable, but what is clear is that their governance was getting increasingly complicated with the expansion of their own internal administration systems and bureaucracies and the difficulties in delivering programs and services to a widely-dispersed and rapidly growing young and largely unemployed population. The Band governance structure set up by the department of Indian Affairs with major decisions requiring assent through Band Council resolutions was still the main means of resolving political problems and for determining public policy and administration. The change in Band governance was therefore not so much structural as it was process. Lacking prescribed processes in formal policy and procedural structures, the ratification of major decisions was done

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<sup>112</sup> Northern Medical Services, Department of Family Medicine, Vital Statistics in Northern Saskatchewan: 1974-88, Saskatoon, Saskatchewan: University of Saskatchewan, 1992, 18-20

<sup>113</sup> Health and Welfare Canada, Medical Services Branch, Saskatchewan Region, The Health of The Registered Indian Population in Saskatchewan, Regina, Saskatchewan: 1989, 37

largely through the influence of informal relationship networks within the communities and through public meetings.

These informal processes of Band governance that rely upon relational networks were not unique to Peter Ballantyne. Both positive and negative scenarios have been raised with respect to the influence of kinship relationships in the politics and administration of bands in general. One scenario suggests that people have lost the power to control their leadership because the traditional governance which historically allowed them to control their leaders through various local structures, customs, norms and values have been replaced by hierarchical authoritarian systems and politicized administrations that have blurred the executive and legislative functions of governance.<sup>114</sup> Individualism and self-interested cooperation have come to characterize Band governance where decisions favor close relatives of the political leadership and administration staff. The only accountability then falls to external funding authorities that can regulate the actions and spending practices of the bands. In this sense, kinship groupings while being a significant political indicator of influence and power<sup>115</sup> have divided rather than united the Band community.

Another scenario suggests that the accountability is being demonstrated through other means such as formal community participation in committees, boards and Band meetings and through informal political relationships between various kinship groupings in the community who have a strong influence in the way resources are

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<sup>114</sup> Boldt Menno, op.cit., 130

<sup>115</sup> Jones Lawrence F, Edward C. Olson, in Political Science Research: A Handbook of Scope and Method, New York, NY: Harper Corlins College Publishers, 1996, describe political resources as "any attributes that an individual, group or nation, can use to influence others," 49

distributed.<sup>116</sup> The formal political administrative structures help to facilitate these informal personal relationships rather than segmenting them into official processes, thus providing direct access to leaders and decision-makers. This scenario suggests that these influences through informal kinship networks in the decision-making processes could be aspects of traditional governance which have been adapted to the formal requirements required by law and by the department of Indian Affairs.

The processes followed by the Peter Ballantyne Band reflect a blend of both formal and informal relationships that have been adapted to the various internal and external changes in the region. The underlying values and expectations of Band communities have changed over time and through the band takeover of programs and services, demands upon the state have increasingly been transferred to Band government. On one hand, Band leadership have been allowed political sanction to develop their own governance structures and pursue new responsibilities, and on the other hand, when they cannot satisfy community expectations, they are faced with some form of political resistance which often leads to community conflict and divisions between kinship groupings.

The scenario leading up to the 1995 Health Transfer Agreement by PBCN was a good example of how complex decision-making had become in band governance. One of the major issues facing the band was whether or not to sign the 1992 Saskatchewan Treaty Land Entitlement Framework Agreement with the federal government, which was a means of settling their outstanding land claims under

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<sup>116</sup> Lithman Yngve Georg, *The Community Apart: A Case Study of A Canadian Indian Reserve Community*, Winnipeg, Manitoba: The University of Manitoba Press, 1984, 142-143, studied the Maple River reserve in Manitoba, which was a more southern type reserve, but provides a useful comparison.



Treaty. The process leading up to the signing was highly politicized with strong divisions between families and challenges to Band leadership; however, it was eventually ratified through a referendum. The other issue, which further complicated the process, involved serious financial problems with a growing band deficit, which was straining the delivery of public programs and raising issues of administrative credibility. In the midst of this, a needs assessment was done in the communities to determine the viability of negotiating a separate Health Transfer Agreement with the regional Medical Services Branch, and while there was agreement to do so, many expressed concerns with the administration and governance aspect. They did not want their health care system jeopardized by the deficit issues in other programs and they wanted a more accountable method of service delivery. To that end, a non-profit corporation governed by an appointed community Board representing the eight PBCN communities was set up with a mandate by Chief and Council to manage and deliver its health services. The tripartite agreement between Health Canada, PBCN and the PBCN Health Services Inc., was a unique governance model since most Transfer Agreements were bilateral Band Agreements. It structurally allowed for direct community (Board) input into the governing of health services with indirect policy support from the Chief and Council.

### **Conclusion**

With the evolution of governance from traditional to elected Band authorities, the PBCN Health model demonstrated a further form of internal devolution of administrative power from the Band to a regional Board of community representatives. PB Health could have been run as a portfolio within the Chief and

Council administration, but it would not have been at arms length, which at the time was the preferred political route. This case study explores the Board's experiences in managing PB Health and dealing with governance issues relating to power and authority, relations, accountability and political culture. The challenges that faced the new Board included such factors as distance and population issues, lack of capital facilities, professional staff shortages and high expectations from the communities and political leadership. PBCN had developed into a multi-community Band<sup>117</sup> made up of eight communities in northeastern Saskatchewan with a combined membership of over 7300 people,<sup>118</sup> over half residing on reserve. The PBCN territory covered much of northeastern and north-central Saskatchewan 454 km north of Prince Albert and 508 km east to the Flin Flon, Manitoba border.<sup>119</sup> Most of the membership lived in the seven northern communities of Pelican Narrows, Deschambault Lake, Southend Reindeer Lake, Sturgeon Landing, Denare Beach, Sandy Bay, Kinoosao, and many others resided in larger urban centers such as La Ronge, Prince Albert, Saskatoon and Regina.<sup>120</sup>

The extent to which traditional kinship values affected the development of PB Health is debatable, but what is clear is that the Board governance was intricately tied into community politics with the Chief and Council system and the dynamics of interrelated family relationships both of which could not be ignored.<sup>121</sup> While many

<sup>117</sup> "Band" here refers to the legislative reference to First Nation groupings under the Indian Act.

<sup>118</sup> Prince Albert Tribal Council Data on PBCN's registered population as of August 2003. Website: [http://sdiprod2.inac.gc.ca/fnprofiles/FNProfiles\\_General Information.asp?BAND\\_NUMBE...](http://sdiprod2.inac.gc.ca/fnprofiles/FNProfiles_General%20Information.asp?BAND_NUMBE...)

<sup>119</sup> PBCN Home & Community Care Plan, May 2001, 5. See also Appendix 1 – Map of the territory

<sup>120</sup> PBCN Community Health Care Plan, January 1995, 1

<sup>121</sup> Dr. Patricia McCormack, Associate Professor with the School of Native Studies at the University of Alberta, who was part of my examining committee made an interesting point that the gender division of responsibilities in politics resembles the traditional model of each gender having its own roles and both working together – as in the PBCN Health case where the Board, mostly women, were able to

perceive PBCN as a Band consisting of homogenous communities under a multi-community Band structure, and while the communities share many cultural similarities, it is apparent from history and current practice that the communities that make up PBCN are different and desire a certain amount of autonomy. Having Board members with positive community profiles and experience in community boards and committees were important determinants for the Chief and Council in the selection of Board members. All the PB communities had local representation on the Board whether or not they were part of the Health Transfer Agreement. The three larger and main communities in the Transfer had 2 members each on the Board and the smallest community in the Transfer had one member. The other communities who were not part of Transfer had one member each. The selection processes consisted of Portfolio Councilors from each of the PB communities recommending Board members who had previously been selected by some form of community nomination process. Chief and Council ratified these selections through a Band Council Resolution. Some communities wanted elections for their Board representatives; others preferred the informal approaches, which called for community applications and appointments by the local Councilors. In this way, individual communities processes largely determined community selections, but the final approval was still with the Chief and Council as a whole. This process was generally how most major Band-wide decisions were made and it reflected the accommodation of the political approval protocols of the communities as well as the approval requirements by funding agencies.

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work effectively with the Chief and Council, which were mostly men. What is significant is that it institutionalizes roles in politics for women particularly in the caring, nurturing service areas like health.



Traditional governance was definitely not a bureaucratic system as far as having lines of hierarchical authority determining the receiving of community benefits, but the Band system changed that with the main power of Chief and Council determining the financial control and access to government programs and benefits. With the PB Health Transfer, the administration power and control over the administration of health funding shifted to the Board but the political power overall still remained with the Chief and Council. In one sense, it was consistent with the distributed nature associated with traditional governance in that it allowed for some power sharing with others in the community apart from the Chief and Council, but it also added another layer of administrative hierarchy in terms of people receiving benefits and programs. If PBCN had been a smaller population Band located in one setting, then perhaps there would have been more costs than benefits associated with having separate governing authorities, but being a regional Band with a large population, people saw more benefits in having a health organization at arms length from the Band structure. As members of the various PBCN communities, the Board members understood the political influence and power of the Chief and Council in all community matters and were therefore cognizant that they had to find ways of working together with them while maintaining their own administrative autonomy under the Transfer Agreement. Modernization may have come to the north, but the communities were still small and isolated enough for Chief and Council to influence all other agencies operating in the communities on a regular basis.

## Chapter 4 The Federal Indian Health Policy Environment

### Introduction

This chapter describes the federal policy environment that helped facilitate the 1995 Peter Ballantyne Cree Nation<sup>1</sup> Health Transfer. It provides a historical context to better understand the evolution of the PBCN Transfer Agreement. The main questions here are why did PBCN decide to transfer and how did their experiences in going through the transfer process influence their resulting transfer agreement? In answering these questions, the chapter focuses on the history of the federal Indian health policy, the trend towards increased devolution of community programs and services to First Nations, and the development of the Indian health transfer policy. The PBCN Transfer is described in more detail in the next chapter, and will only be discussed here in order to situate PBCN within the larger federal policy environment. It will describe the motivating factors behind the Transfer and the steps that were taken to work out the required approvals from the community and federal government.

The Pre-Transfer and Transfer requirements were based on a defined series of steps set out by MSB<sup>2</sup> for all Transfer Bands requiring them to conduct comprehensive health needs assessments, develop community health plans, get into negotiations, sign their Agreements, implement them and evaluate them at the end of their Transfer periods. It was a national process aimed at providing a consistent

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<sup>1</sup> PBCN or Peter Ballantyne Band will be used interchangeably to refer to the Peter Ballantyne Cree Nation as a group. The term Peter Ballantyne Band is used in federal documents because of the legal definition of "Band" under the Indian Act, whereas PBCN is a political term preferred by the Band leadership.

<sup>2</sup> MSB is an acronym for the Medical Services Branch of Health Canada, the branch responsible for Indian health services until it was renamed to FNIHB (First Nations Inuit Health Branch).

method for devolving health services to First Nations across Canada. PBCN was no different, however it was at the implementation stage where Bands took different paths in terms of governance systems and in the case of PBCN, the preferred non-profit organization method for delivering health services created a new type of Transfer Agreement, unlike the others. While most agreements were bilateral between First Nation bands and MSB, PBCN was a tripartite agreement between PBCN, MSB and a non-profit organization, PBCN Health Services Inc., governed by a community board. The Chief and Council on behalf of the PBCN membership elected the board of directors and gave them the authority and mandate to manage and control the delivery of health services to their communities. This meant that the health funding went directly to the organization with the condition that it would be expended on health related programming and not on PBCN deficit reduction measures. At the time, the PBCN leadership was facing serious accountability and credibility issues arising from their deficit situation and problems with getting community ratification for the settlement of their outstanding land claims under the 1992 Treaty Land Entitlement Framework Agreement.

The PBCN commitment to Transfer was strong as evidenced by the various process challenges the leadership had to overcome in negotiating the Five-year Transfer Agreement. According to key internal documents such as the Community Health Plan and the Transfer Agreement itself, and notwithstanding the financial problems, both the PBCN Chief and Council and MSB were primarily motivated to enter into Transfer negotiations because of their political desire to work towards self-government objectives. Emphasis was on more community control over local



programs and services, and the improvement and replacement of the fragmented type of health services that were previously available with a more comprehensive and culturally appropriate health system.

### **History of Federal Indian Health Policies & Practice**

According to T.Kue Young, the first experiences that the Indians in the sub arctic had with modern medicine and the federal healthcare system were probably through the annual visits by "physicians attached to the annual government treaty party."<sup>3</sup> This was probably true of the Peter Ballantyne experience as well considering that the fragmented nature of health services between 1895 and 1945 did not improve until after the Second World War. Historical accounts indicate that Indian agents dispensed most of the medical services to Indians either directly or through others like priests, trading post managers, missionaries and RNWMP. In 1896, for example, the health and sanitary conditions of the Indians were described as being good, although there were also reports of diphtheria, typhoid fever, measles, whooping cough, chicken pox epidemics, and pulmonary attacks. Efforts were made by the agents to encourage people to better ventilate their houses, eat more fresh meat, roots and vegetables in their diets.<sup>4</sup>

In 1902, reports indicated that "survival of the fittest" was the main means of northern adaptation to new diseases like TB, smallpox, whooping cough, scarlet fever, typhoid fever, but the greatest death toll directly or indirectly was through TB. Some health statistics of the North West Territories showed 506 births and 487 deaths

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<sup>3</sup> Young T. Kue, Health Care and Cultural Change: The Indian Experience in the Central Subarctic, Toronto: University of Toronto Press, 1988, 81

<sup>4</sup> Indian Affairs and Northern Development: Indian Affairs Annual Report: 1896

in 1902, and in 1904, 495 births and 446 deaths were recorded.<sup>5</sup> In response to the high death rates among the Indian population compared to the national average, a medical superintendent was hired in 1905 to provide remedial measures, monitor contagious disease, refer TB patients to "sanatoria, hospitals or tents" and hire medical officers.<sup>6</sup> Medical reports in 1906 attributed the TB epidemic to overcrowded houses which had little ventilation in the winter, and tents were seen be a better alternative.

By 1917 departmental hospital facilities and services were slowly being developed in Canada, but prior to that "temporary tent hospitals were used for isolating smallpox and tuberculosis patients in the reserves. By the mid-1930s there were a total of seven departmental hospitals, ranging from eight to forty beds each."<sup>7</sup> In 1921, plans were being made to put a medical group of nurses in Regina to provide mobile nursing services to reserves in support of physicians.<sup>8</sup> In 1930, the first nursing station was set up on the Fisher River reserve in Manitoba.

In 1926, the policy of Indian Affairs in the Saskatchewan region was to use municipal hospital facilities through special funding arrangements with the provincial government. For example, forty beds in the Qu'Appelle sanatorium were made available for Indian patients with TB. There was also mention of the difficulty of getting the older patients to switch from using Indian medicine men, but the preference was changing with the increased usage of hospitals and medical

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<sup>5</sup> Indian Affairs Annual Reports in 1901, 1904

<sup>6</sup> Indian Affairs Annual Report: 1905

<sup>7</sup> Young T. Kue, Health Care and Cultural Change: The Indian Experience in the Central Subarctic, Toronto: University of Toronto Press, 1988, 87

<sup>8</sup> Indian Affairs Annual Report: 1921

practitioners.<sup>9</sup> In 1928, the department was also cost-sharing services for Indians from northern facilities like the hospital in Ile-A-La-Crosse. For remote areas, over 250 traveling medical doctors provided itinerant services across Canada, but the reports don't show how many were in Saskatchewan.<sup>10</sup> In 1939, with the northern areas experiencing increasing epidemics such as influenza, whooping cough, scarlet fever, and TB, the department hired a medical superintendent located in Prince Albert to provide services to surrounding reserves and to the remote northern bands.<sup>11</sup> In 1962, the department's policy of negotiating cost-sharing agreements with the provinces for the provision of medical care to Indians had become standard practice.<sup>12</sup>

The financial history of Indian affairs in providing Indian health services was marked by budgetary constraints and administrative disorganization and it was not until after 1945 that the situation improved. The Indian health costs for 1931 were estimated at \$1 million for a Treaty Indian population of about 110,000 which was just under \$10 per person in comparison to \$31 per person spent in the general population.<sup>13</sup> In 1933, the budget was cut to \$793,000 or from \$10 to \$7.20 per person.<sup>14</sup> In 1944, the Department of National Health and Welfare Act was passed and in 1945, the mandate for Indian Health services was transferred from Indian Affairs to the federal health department.

The administration of Indian health services under the Health department was organized into regions and zones across the country. By 1960, over 22 hospitals, 30

<sup>9</sup> Indian Affairs Annual Report: 1926

<sup>10</sup> Indian Affairs Annual Report: 1928

<sup>11</sup> Indian Affairs Annual Report: 1939

<sup>12</sup> Indian Affairs Annual Report: 1962

<sup>13</sup> Indian Affairs Annual Report: 1931

<sup>14</sup> Young T. Kue, Health Care and Cultural Change: The Indian Experience in the Central Subarctic, Toronto: University of Toronto Press, 1988, 88



clinics, 37 nursing stations, 83 health centers were built and over \$23 million was spent on providing these services.<sup>15</sup> In 1962, the administration was changed with the formation of the Medical Services Branch or MSB, which became responsible for the Indian Health program, and while it has been reorganized many times, and had its name changed in the mid-1990s, it has remained as the primary federal agency for Indian health services.

The evolution of Indian health policies and the provision of itinerant health services were historically based on medical relief, and managing crises such as epidemics, and improvements only came with expanded administration and program budgets. T. Kue Young described the early period as "the years of benign neglect," where the philosophy of Indian Affairs was geared towards minimum public assistance.<sup>16</sup> The history of Indian Health is rooted in the fiduciary relationship between the federal government and the Indian people, but with the provinces having jurisdiction over health, the matter of who was responsible for Indian services was never clarified especially with respect to off-reserve services.<sup>17</sup>

### **Issues of Jurisdiction and Responsibility**

The Indian people<sup>18</sup> have argued that the right to Indian health services is rooted in Treaties predating the Indian Act. However, official federal policy has consistently held that the responsibility of the federal government is based on legislated authority provided through section 73(1) of the Indian Act which gave

<sup>15</sup> Young T. Kue, *ibid.*, 88

<sup>16</sup> Young T. Kue, *ibid.*, 90

<sup>17</sup> Franks, C.E.S., *The Public Service in the North: Canadian Public Administration*, Vol.27, No.2, (summer 1984), 210-241

<sup>18</sup> The terms "Indian" and First Nation will be used interchangeably to refer to status Indians as a group. "Indian" is used in federal documents because of their legal status under the Indian Act; "First Nation" is a political term denoting the nation to nation status of indigenous government, but it basically refers to the group of status Indians who are defined as Indians in the Indian Act.

regulatory power to the Minister of Indian Affairs to 'prevent, mitigate and control the spread of diseases on reserves; to provide medical treatment and health services for Indians; to provide compulsory hospitalization and treatment for infectious diseases... and to provide for sanitary conditions ...on reserves.'"<sup>19</sup> Jurisdiction for Indian health care is as Wayne Warry notes, "poorly drawn."<sup>20</sup> The federal government has exclusive jurisdiction over "Indians and lands reserved for Indians" under section 91(24) of the Constitution Act of 1867, but the jurisdiction for health care remained a provincial responsibility under s. 92(7).<sup>21</sup> Although First Nations resolutely hold that health is a treaty right and while there are certain provisions in the 1982 Constitution Act recognizing and affirming existing aboriginal and treaty rights of Indian people, the federal government has failed to define the meaning or scope of "existing rights,"<sup>22</sup> and has as resolutely as the First Nations, held that Indian health services are a matter of policy and not a treaty right.

The provincial responsibility with respect to Indian Health has been through a general provision of insured services that became available to all citizens of the province in 1961 in the form of Medicare or the Saskatchewan Medical Insurance Act. It provided universal, compulsory insurance coverage for the service fees paid to

<sup>19</sup> Young T. Kue, Health Care and Cultural Change: The Indian Experience in the Central Subarctic, Toronto: University of Toronto Press, 1988, 83; also, Carswell, Consolidated Native Law Statutes, Regulations and Treaties, 1994, Scarborough Ontario: Thomson Canada Ltd., 1993, 34

<sup>20</sup> Warry Wayne, Unfinished Dreams: Community Healing and the Reality of Aboriginal Self-Government, Toronto: University of Toronto Press Incorporated, 1998, reprinted 2000, 120

<sup>21</sup> Manga Pran, Laurel Lemchuk-Favel, Health Care Financing and Health Status of Registered Indians, Ottawa: Assembly of First Nations, First Nations Health Commission Study, August, 1993

<sup>22</sup> Cassidy Frank and Robert L. Bish, Indian Government: Its Meaning in Practice, Lantzville, B.C.: Oolichan Books, and The Institute For Research on Public Policy, 1989, 16; and Pran Manga, Laurel Lemchuk-Favel, Health Care Financing and Health Status of Registered Indians, Ottawa: Assembly of First Nations, First Nations Health Commission Study, August, 1993,

physicians and surgeons.<sup>23</sup> In 1966, the federal government followed the Saskatchewan model of medicare and passed the National Medical Care Act which also provided comprehensive, universal health insurance benefits to every citizen including hospital and physician services. The national health insurance was based on federal standards and cost-sharing provisions with the provinces in the delivery of health care.<sup>24</sup> In 1978, a policy directive by the Medical Service Branch of Health Canada provided special coverage for Indian people for services not covered under either plan, through the non-insured health benefits program (NIHB), which provided for the payment of such items as prescription drugs, glasses, dental care, and medical transportation.<sup>25</sup> The provincial position is that the federal government has responsibility over health services on reserve, regardless of the provision under section 88 of the Indian Act which could enable the general application of provincial laws to Indians on reserve in the absence of federal laws or band bylaws,<sup>26</sup> but this provision had never been utilized for a variety of political and economic reasons.

The political position of the First Nations is that they consider health to be a treaty right, but the federal government has consistently argued that Indian health was a matter of policy based on humanitarian and not legal grounds, and this position has

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<sup>23</sup> Grey Gwendolyn, Federalism And Health Policy: The Development of Health Systems in Canada and Australia, Toronto: University of Toronto Press, 1991, 40

<sup>24</sup> Wotherspoon Terry, Vic Satzewich, First Nations: Race, Class and Gender Relations, Scarborough Ontario: Nelson Canada, 1993, 161

<sup>25</sup> Young T. Kue, op.cit., 92

<sup>26</sup> Carswell, Consolidated Native Law Statutes, Regulations and Treaties, 1994, Scarborough Ontario: Thomson Canada Ltd., 1993, 39, 40



not changed.<sup>27</sup> While specific references to health were contained in the medicine chest clause in Treaty 6 that was signed in 1876 in Saskatchewan, and later adhered to other bands such as Peter Ballantyne in 1895, the interpretation and scope of medical services implied by the clause was never settled between the First Nations and federal government. In 1966, Health Canada stated that there was nothing in the Department of National Health and Welfare Act which gave the Minister "responsibility for medical services to Indians and Eskimos, except the general responsibility the Minister (had) in respect of the public health of the people of Canada,"<sup>28</sup> and in 1979, the official position was essentially the same under the Indian Health Policy which "removed the issue of treaty rights from health policy considerations to where it rightly belonged - Indian Affairs."<sup>29</sup> While the treaty right to health issue has not been resolved even at the federal administrative levels between Health Canada and Indian Affairs departments, the provision of Indian health services on reserve and coverage of certain non-insured health benefits off-reserve continue to be the mandate of Health Canada.

The assimilation or civilization policy has been the common thread in the history of government management of Indian health services with the goal being the eventual removal of the special status of Indian people and the transfer of health services from the federal to provincial responsibility. The federal policy environment changed in 1969 with the failure of the White Paper policy which had proposed to

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<sup>27</sup> Young T. Kue, op.cit., 82; also article by Favel-King, Alma, "The Treaty Right to Health," in The Path To Healing. Report of the National Round Table on Aboriginal Health and Social Issues. Ottawa: Royal Commission on Aboriginal Peoples, 1993, 120 - 129

<sup>28</sup> Young T. Kue, op.cit., 84

<sup>29</sup> Health Canada, Ten Years of Health Transfer: First Nation and Inuit Control, Ottawa: Minister of Public Works and Government Services Canada, 1999, 2

remove the treaty status of Indian people, repeal the Indian Act, phase out the department of Indian Affairs, do away with Indian reserves, and transfer the delivery of all Indian services to the provinces.<sup>30</sup> The growing influence of Indian organizations at the national and provincial levels in the early 1970s had been instrumental in changing the policy focus towards the protection of the treaty relationships with the federal government, federal responsibility for health care, and increased community control over government-delivered programs and services.<sup>31</sup> The National Indian Brotherhood, the forerunner to the Assembly of First Nations, for example, succeeded in advocating for the provision of non-insured services to Indian people by the federal government in 1978 that led to other federal policy developments in Indian Health across Canada. At the provincial level, by 1970, the Federation of Saskatchewan Indians had developed into an effective organization making political gains in advocating for Treaty rights and Indian control over services, especially in the area of Indian education which resulted in many bands setting up their own school boards on reserves.<sup>32</sup>

### **Policy Trends Toward Increased Community Control**

In 1975, the federal government produced a policy framework entitled "The Canadian Government/Canadian Indian Relationships," which called for increased Indian control over programs and services, which resulted in the signing of contribution agreements with Indian Bands to manage certain programs in their communities. In the area of health, the Native Alcohol and Drug Abuse Program

<sup>30</sup> Health Canada, *ibid.*, 1; also T. Kue Young, *op.cit.*, 91, 92; Menno Boldt, Surviving as Indians: The Challenge of Self-Government. Toronto: University of Toronto Press, 1993, 18

<sup>31</sup> Health Canada, Ten Years of Health Transfer, *op.cit.*, 1; and T. Kue Young, 1988, *op.cit.*, 92;

<sup>32</sup> Wheaton Cathy, The Role of Treaties in the History of Saskatchewan Indian Politics 1910 to 1992, in <http://www.sifc.edu/Indian%20Studies/IndigenousThought/fall99/cathypaper.htm>. 13, 14

(NNADAP) and the Community Health Representative (CHR) programs were set up.

<sup>33</sup>The NNADAP program was designed to set up community alcohol and drug abuse prevention and treatment (counseling) programs on reserves. The CHR program was set up to hire community health representatives to act as liaisons between the people and the medical staff by providing language translation and other support services. Both programs still exist today and have been integrated into most health transfer agreements, including the one with the Peter Ballantyne Cree Nation.

In 1979, the federal government produced their Indian Health Policy which sought to improve the poor health status of Indian communities by facilitating First Nation community control and administration over health services at their pace and discretion. Also in response to concerns regarding the government-imposed guidelines on the provision of non-insured health benefits to status Indians, the authority to approve the payment of benefits was changed to licensed medical and dental professionals. The policy changes came from varied sources: the growing political pressure by Indian organizations for more control; the continuing poor health status of Indian people under the MSB medical model and the need for a more holistic and integrated approach to healthcare; the influence of the 1978 Alma Ata Declaration by the World Health Organization promoting the primary health care strategy for its member nations, including Canada, for the development of basic

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<sup>33</sup> *ibid*, 1, 2; also, Wayne Warry in *Unfinished Dreams: Community Healing and the Reality of Aboriginal Self-Government*, Toronto: University of Toronto Press Incorporated, 1998, 95; also, T. Kue Young 1988, *op.cit.*, 95



health infrastructures and support services at the community level or the first line of delivery.<sup>34</sup>

The health policy directive by the World Health Organization sought to improve health for all by the year 2000 through the primary care approach characterized by integrated district health systems delivering accessible, culturally appropriate and affordable services, maximizing the use of local resources, providing nutritious food, safe water, basic sanitation facilities, immunization, essential medication and treatment, health education, trained medical and support staff, having organized interagency coordination and full community participation in the governing and delivery of the services.<sup>35</sup> With this directive in mind, the federal health department proposed that the implementation of the Indian health policy would be based upon three pillars, namely:

- (1) Community development, both socio-economic and cultural/spiritual, to remove the conditions which limit the attainment of well-being; (2) the traditional trust relationship between Indian people and the federal government; and (3) the interrelated Canadian health system, with its federal, provincial, municipal, Indian and private sectors."<sup>36</sup>

The various initiatives that resulted from the policy included more program transfers from MSB to Band administrations, including the employment of community health representatives and some nurses, and in 1982, the community health demonstration program provided funding for bands to manage some local programs on a pilot basis at the community level, but this lasted for only two years.

<sup>34</sup> Young David E., Leonard Smith, The Involvement of Canadian Native Communities in their Health Care Programs: A Review of the Literature Since the 1970's, Edmonton, Alberta: Canadian Circumpolar Institute, University of Alberta, 1992, 3; also, Brenda Shestowsky, Traditional Medicine and Primary Health Care Among Canadian Aboriginal People: A Discussion Paper with Annotated Bibliography, Ottawa, Ontario: Aboriginal Nurses Association of Canada, 1993, 5

<sup>35</sup> *ibid*, 5

<sup>36</sup> Health Canada, Ten Years of Health Transfer, op.cit., 2; also T. Kue Young 1988, op.cit., 93

The move towards more local control continued with more government sponsored studies and inquiries. In 1980, a commission of inquiry led by Mr. Justice Berger, a well known aboriginal rights scholar and former commissioner of the Mackenzie Valley Pipeline Inquiry, was set up to determine how the government could achieve a more substantive means of consultation with First Nations over their health care, and the report recommended more sustainable annual funding to Indian organizations and communities were needed for this to happen.

In 1983, a federal special committee on Indian self-government, led by Keith Penner, a Liberal Member of Parliament, produced a report recommending among other things, the recognition of Indian self-government with full legislative and policy-making powers, the enhancement of the special status of Indians under the Constitution, and in the area of health, that Indian health services be transferred to the control of Indian self-government structures. The federal response, however, was limited to the recognition of the need to establish a new relationship through a form of Indian self-government which promoted more devolution of functions, powers and services to bands with Indian Affairs acting in more of an auditing and monitoring role with respect to the distribution and accounting of public funds. Medical Services Branch also limited the interpretation of the transfer of control to mean the devolution or transfer of services within existing service structures.<sup>37</sup>

Devolution policies generated mixed reactions among the Indian communities. While most acknowledged that it provided a means for increasing local control over community services, it was also seen as a means of implementing the

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<sup>37</sup> Health Canada, *Ten Years of Transfer*, op.cit., 2; also Menno Boldt, *Surviving as Indians: The Challenge of Self-Government*, Toronto: University of Toronto Press, 1993, 90, 91; also, T. Kue Young 1988, op.cit., 95

federal government's agenda to limit or avoid responsibilities in Indian health, rather than meeting the First Nations' agenda of designing local institutions reflective of community needs and value systems.<sup>38</sup> In spite of the limitations of devolution, many bands took advantage of the available transfer programs primarily due to the lack of other alternatives for local control and many saw it as a step towards self-government.<sup>39</sup> It allowed them to develop governance and administration experience in public service delivery albeit within the confines of funding agreements and federal policy and program guidelines. Cassidy and Bish referred to this as a temporary accommodation where Indian governments asserted inherent and independent jurisdiction on one level, and accepted and implemented delegated jurisdiction on another level.<sup>40</sup>

#### **The Indian Health Transfer Policy**

In 1986, the federal government produced the Indian Health Transfer Policy that opened the way for many Bands to begin taking over the administration and delivery of certain health programs to Bands from MSB. The transfer agreements changed the historical MSB-First Nation relationship with respect to the way Indian health services were managed and delivered to Indian reserves. For those Bands that signed transfer agreements, the role of MSB shifted from direct management and delivery of services to a more supportive role in terms of providing program funding, information exchange, and monitoring the progress of the terms of the agreements in

<sup>38</sup> Mercredi Ovide, Mary Ellen Turpel, *In The Rapids et.al.*, 1994, 93 ; Fleras Augie, Leonard Elliot, *The Nations Within et.al.*, 1992, 45

<sup>39</sup> Warry Wayne, *Unfinished Dreams: Community Healing and the Reality of Aboriginal Self-Government*, Toronto: University of Toronto Press Incorporated, 1998, 94-95

<sup>40</sup> Cassidy Frank, Robert L. Bish, *Indian Government: Its Meaning in Practice*, Lantzville, B.C.: Oolichan Books and the Institute for Research on Public Policy, " 1989, 156, 157



areas such as the delivery of mandatory programs and other requirements, the annual reporting of financial statements and program evaluations, and the promotion of community accountability.

The scope of the transfers allowed for a variation of first, second or third level services depending on the capacity and size of the Bands or tribal councils requesting transfer. First level was community-based program delivery; second and third levels were supervisory, coordination, and consultative services. The objectives of the Indian Health Transfer policy were to:

- "To enable Indian bands to design health programs, establish services and allocate funds according to community health priorities;
- To strengthen and enhance the accountability of Indian Bands to Band members;
- To ensure public health and safety is maintained through adherence to mandatory programs."<sup>41</sup>

In 1988 the Cabinet passed the health transfer policy framework which provided the authority to transfer programs to Band control and in 1989, Treasury Board approved the funding authority and mechanism to support a developmental approach to transfer consisting of three phases: pre-transfer planning, bridging, and Transfer implementation. The pre-transfer phase required a Band or tribal council to submit a planning proposal supported with a Band council resolution and letter of audit. Funding would then be provided to set up a health management structure and to provide training, conduct a community health needs assessment and develop a community health plan. The bridging phase involved presenting the community health plan before an MSB review committee for approval and drawing up a

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<sup>41</sup> Gibbons Adrian and Associates, Short-Term Evaluation of Indian Health Transfer, Victoria, B.C.: 1992, p.i

memorandum of understanding detailing the funding requirements and other program and implementation clauses. These would then be integrated into a transfer agreement which would set out the terms of reference and responsibilities of each of the signatory parties with respect to implementation, reporting and evaluation requirements.<sup>42</sup>

According to federally sponsored evaluations of the Indian Health Transfer initiatives in 1992 and 1995, the outcomes were generally positive experiences for the transferred bands, and this view was further supported by the growth in transfers since then. By 1999, out of a total of 599 eligible communities in the MSB regions across Canada, 41% had signed transfer agreements through individual band or multi-community transfers, with 58 % projected to 2004. In Saskatchewan, out of a total of 83 eligible communities, 59 or 70% had signed agreements, with 84% projected for 2004.<sup>43</sup>

The short term evaluation in 1992 conducted eight community case studies of bands who had transferred prior to 1991 and they found that most bands took over transfer to further the process of self-government, to increase local opportunities for employment, to improve responses to community health priorities and needs, to better design appropriate programs, and improve the health status through new initiatives. Their concerns included the perceived threat to treaty rights to health, the federal responsibility over Indian health, the off-loading to the provinces and the limitations of funding policies. It was generally agreed that successful transfers required strong,

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<sup>42</sup> Health Canada, Transferring Control of Health Programs to First Nations and Inuit Communities: Handbook 1- An Introduction to Three Approaches, Ottawa: Program Policy, Transfer Secretariat and Planning Directorate, Medical Services Branch, Health Canada, 11 – outlines the framework, attached as appendix

<sup>43</sup> Health Canada, Ten Years of Transfer, et.al., 1999, 19

broadly representative health committees or boards, supportive political leadership, good communications, knowledge of the potential benefits and limitations by the community leadership, and flexible timelines and processes.<sup>44</sup>

In 1995, long term evaluation set out to determine whether the transfer objectives set out in 1986 were met, to assess the impacts and effects of transfer and to identify alternatives to the transfer process.<sup>45</sup> The report generally found that the objectives were achieved at the community level in terms of better responding to community health priorities, increasing the level of awareness of health issues, applying culturally sensitive and holistic methods of service delivery and improving integration with other programs and services such as social services, mental health, non-insured health benefits and education.<sup>46</sup> Problems encountered in the transfer process were generally associated with limitations around authority, human resource capacity, appropriate funding and quality assurance issues. First Nations wanted involvement in policy formulation as opposed to just service administration. The residual role of MSB with respect to the support, supervision, training and consulting services to transferred bands was not clarified nor demonstrated at the community level thus raising issues of service quality.<sup>47</sup>

The long-term evaluation report indicated that the transfer Bands in Saskatchewan were concerned with the ongoing and underlying uncertainties with respect to the potential abrogation by the federal government of the treaty rights to

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<sup>44</sup> Gibbons Adrian, Short-Term Evaluation of Indian Health Transfer, Victoria, BC: Adrian Gibbons and Associates, 1992, ii-iii

<sup>45</sup> Health Canada, Long Term Evaluation of Transfer: Final Report, Ottawa: Institute for Human Resource Development, 1995, 1

<sup>46</sup> *ibid*, 2, 3; also Health Canada, Ten Years of Transfer, *op.cit.*, 15

<sup>47</sup> Health Canada, Long term Evaluation, *op.cit.*, 7-12



health care, the overlapping confusion of federal-provincial responsibilities, and the potential impacts of the various provincial health care reforms on First Nations. In Saskatchewan, treaty six had the famous medicine chest clause which promised that a "medicine chest (would) be kept at the house of each Indian Agent for the use and benefit of the Indians at the direction of the Agent."<sup>48</sup> The First Nations interpreted this to mean that the federal government was responsible for providing all the health services that they required for good health, and that health transfers could potentially be used by the federal government to justify moving away from their responsibilities because they were no longer providing direct services to the communities.

Some of the factors that contributed to positive experiences with health transfers in Saskatchewan included flexibility, improved relations and communications with MSB, more community control, sufficient pre-transfer planning resources, helpful guidance through the community needs assessments and community health plan requirements, good political and technical support, commitment to community development and capacity building, health committee training, support for holistic and team approaches to planning, and support by the community and local staff in the development processes.<sup>49</sup> The ability to develop culturally appropriate processes under the transfer policy was seen as positively contributing to a variety of approaches ranging from the hiring of local First Nations staff, the use of traditional healers and ceremonies, community gatherings, hiring elders as resource advisors, focusing on emotional and spiritual health as a means of achieving wellness and using talking circles for community participation in planning.

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<sup>48</sup> Health Canada, Long Term Evaluation, ibid, 38

<sup>49</sup> Health Canada, Long Term Evaluation, ibid, 39

In the process, however, many issues were starting to develop around the legal and cultural ramifications between the practice of traditional medicine and the medical health model. Traditional medicine is not insurable, and many were concerned with the risks of potential liability associated with it.<sup>50</sup>

Some of the negative factors in the transfer process were identified as discomfort by some bands regarding the role of MSB representing them at the MSB headquarters in Ottawa, the formula driven funding approach used by MSB as opposed to a needs based approach, dealing with political changes caused by band elections during the process especially for tribal councils transfers, lack of understanding of the process at the political level, lack of governance training for boards and health committees, problems with raising community awareness and support, rigid guidelines with no opportunities for program enrichment, limited understanding by MSB regarding multi-community bands, restrictions around negotiating for proper staff benefits, unsettled issues over non-insured health benefits, concerns with MSB not dealing with treaty rights issues and financial implications associated with population increases.<sup>51</sup>

#### **The PBCN Health Transfer**

By the time the Peter Ballantyne Cree Nation proposed to take over their health Transfer in 1995, they were able to benefit from the supportive political and policy environment at the federal level, as well as the experiences from the other transfer bands. In the PBCN case, their political affiliation with the Prince Albert

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<sup>50</sup> Health Canada, Long Term Evaluation, *ibid*, 40

<sup>51</sup> *ibid*, 40

Tribal Council<sup>52</sup> was useful in that they were able to take advantage of the developmental work that had been done by the Tribal Council in their Transfer especially as it related to the Pre-transfer requirements like the community needs assessments and community health plan and the development of policy, program and operational manuals. The Tribal Council had signed their Health Transfer Agreement in 1990 and was already delivering a variety of health services to their 12 member Bands including PBCN, before PBCN signed its own Transfer. The Tribal Council was also part of the national health transfer evaluations that were done in 1992 and 1995.

In 1990-1995, the delivery of health services to the PBCN membership was rather fragmented in both the reserve and non-reserve communities. The services to the reserve communities of Deschambault, Pelican Narrows, Southend and Sturgeon landing were managed between MSB, the PBCN band administration and the Prince Albert Tribal Council on reserve. The province through Northern Health Services handled the non-reserve communities of Sandy Bay, Denare Beach and Kinoosao. The reserve status affected the eligibility of being included in the Health Transfer Agreement, and when it was signed in 1995, it only included the four reserve communities with the rest continuing to receive provincial services.

By the time of the Transfer renewal in 2000, these non-reserve communities were engaged in a Treaty Land Entitlement process to transfer to reserve status and upon receiving it, the expectation was that it would entitle them to be incorporated into the Health Service Transfer Agreement. Unfortunately, only Kinoosao succeeded

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<sup>52</sup> The PATC has since changed its name to PAGC or the Prince Albert Grand Council, but will be referred to here as the Prince Albert Tribal Council.



in getting full reserve status but could not be integrated into the renewed Transfer Agreement because of a gap in the federal Health Transfer Policy which did not consider the provision of new funding for the new reserves created under the 1992 Saskatchewan Treaty Land Entitlement Framework Agreement. A policy for Treaty land entitlement claims was subsequently added with provisions for a case-by-case negotiation process and the establishment of a federal ad hoc committee who would review the TLE claims, but unfortunately, these did not resolve the funding issues.<sup>53</sup> In the case of Kinoosao, the MSB regional office in Regina provided some interim measures through a few program contribution agreements added to the PBCN Transfer agreement.

Most of the services delivered by MSB prior to Transfer were the community-level or first level health services provided by nurses and visiting medical professionals working out of the nursing stations. The PBCN services were limited to the management of contribution agreements signed with MSB to hire local addiction workers under the Native Alcohol and Drug Abuse Program (NNADAP) and community health workers through the Community Health Representatives (CHR) program. The Prince Albert Tribal Council through their Transfer Agreement provided most of the second level or supervisory, coordination and specialized medical services such as the medical and environmental health officers.

Community participation in health services in this Pre-transfer environment was through local health committees who provided advisory functions to the health clinic staff and political leadership. According to reports gathered from Pre-transfer

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<sup>53</sup> Health Canada, First Nation and Inuit Health Branch, Program Policy, Transfer Secretariat, and Planning Directorate, Health Funding Arrangements, Policy For Treaty Land Entitlement Claims, Ottawa: Health Canada, August 2000, 1-4, also note that FNIHB was previously called MSB.

community surveys, the health committees generally had six members and their activities were described as intermittent around general concerns with community health problems such as housing, communication, treatment and programs in the clinics, the role of the community health representatives, care of elders, nursing turnovers, garbage disposal, dog control, and other problems. There were also requests for more training with respect to the roles and functions of committees, and more education on health issues so that the health committees would more proactive rather than reactive.<sup>54</sup> There was an indication of a perception that health committees could be stronger and more effective if they were able to have more than an advisory role in the governance of their local health system.

The decision by the PBCN leadership to enter into the Health Transfer process was initiated by a variety of factors such as the political desire to have more community control over the management and delivery of their own health system which they believed would provide more holistic, responsive and culturally appropriate services.<sup>55</sup> They had also experienced and been aware of the positive results with other program transfers in the province, and they wanted to integrate the fragmentation of health services under one agency. The PBCN Health Transfer amalgamated most of first and second level services that had been divided between MSB and the Prince Albert Tribal Council. When they took control over their own

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<sup>54</sup> The Peter Ballantyne Cree Nation, from the "Health Committee" sections of the Southend, Pelican Narrows, Deschambault Lake Health Care Needs Assessment For The Members Of The Peter Ballantyne Cree Nation reports, Pelican Narrows: July 1991, prepared by Jackie Carter and Diane Martz.

<sup>55</sup> PBCN Health Services Inc., Directional Plan: 1995, Prince Albert, Saskatchewan: PBCN Health Services Inc., 1995, 2, 3

health services in 1995, PBCN withdrew from the Prince Albert Tribal Council Transfer Agreement.

One of the side effects of Health Transfer was that it shifted power and financial resources from the Tribal Council to the PBCN Band which could have potentially caused political and financial instability for the Tribal Council had they not been large and diversified enough to sustain the size of the loss. These types of discretionary program withdrawals by Bands from their Tribal Councils were a common practice across Canada. While Tribal Councils are a recognized form of political organization at the regional level, their authority is subservient to that of the individual Bands who are recognized under the Indian Act, and in cases of conflict with respect to issues of political jurisdiction, power, distribution of resources, service delivery and accountability, the autonomy of the Bands is paramount.<sup>56</sup>

The dual mandates that Tribal Councils have as both political organizations and service delivery agents, place them in tenuous and often conflicting positions with individual Bands. While they are administering federal programs premised on concepts of self-government and community development, successful Transfers also place at them at risk in losing their own control and funding to Bands who wish to administer their own programs. For example, in the PBCN Transfer, the potential loss to the Prince Albert Tribal Council amounted to over \$17.8 million or an average of \$3.6 million per year over five years, with the exception of the environmental health officer services which they agreed to continue providing to PBCN from their Agreement. While this did create some strains in the political relationship between

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<sup>56</sup> Warry Wayne, *Unfinished Dreams et al.*, op.cit., 1998, 56, 57; also, Cassidy Frank, Robert L. Bish, *Indian Government et.al.*, op.cit., 1989, 89, 90



the Tribal Council and PBCN leadership, it did not jeopardize the Tribal Council's operations to the extent of affecting PBCN's affiliation with them.

The PBCN Transfer process was not unique in the sense of diverging from the well-developed process set out by MSB for all Transfer Bands to follow. They first had to prove their eligibility to enter into the Transfer process by producing a political mandate through a Band Council Resolution (BCR) indicating approval for the proposal and evidence to indicate successful financial and administrative experience in managing other community programs. Secondly, they entered into the Pre-transfer planning phase where they were funded to set up a health management structure, conduct a comprehensive needs assessment of all their communities, and begin working on a community health plan. Thirdly, the bridging phase required them to get their community health plan approved by MSB, negotiate a memorandum of understanding with MSB based on the outcomes of the community research outlining the terms of reference of the signatories, funding requirements and other specific clauses. Fourthly, after the signing of the Transfer Agreement, the implementation phase followed with services being delivered according to the PBCN community health plan and in accordance to all the reporting requirements of the Agreement including an annual report containing audited financial statements, program reports and an evaluation of the Transfer at the end of the five year period.<sup>57</sup>

## **Conclusion**

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<sup>57</sup> PBCN Health Services Inc., *Directional Plan: 1995*, "Prince Albert, Saskatchewan: 1995, 2-3; also, Health Canada publication, *Transferring Control of Health Programs to First Nations and Inuit Communities: Handbook 2, The Health Services Transfer*, Ottawa: Program Policy, Transfer Secretariat and Planning Directorate, Medical Services Branch, Health Canada, 1999, 1

With the completion of the Community Health Plan with all its mapping of the proposed PBCN health system of governance and service delivery, the PBCN Health Transfer Agreement was signed on March 17, 1995. The five-year tripartite Health Agreement between PBCN, PBCN Health Services Inc., and MSB on behalf of Health Canada transferred the management of health services to PB Health in the four northern communities of Deschambault, Southend, Pelican Narrows and Sturgeon Landing. What was not transferred were the various third level services provided by MSB such as the Non-Insured Health Benefits Program (NIHB) which included medical transportation, dental, medical equipment, medical supplies or prescription medication, as well as the fixed assets such as health clinics and other permanent structures.<sup>58</sup>

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<sup>58</sup> PBCN Health Services Inc., Health Transfer Evaluation Plan, Prince Albert: PBCN Health Services Inc., September 1, 1996, 1

## CHAPTER 5

### THE PBCN HEALTH TRANSFER AGREEMENT

#### Introduction

The Health Transfer Agreement was a tripartite agreement signed on March 17, 1995 between PBCN, MSB and PBCN Health Services Incorporated.<sup>1</sup> It was to provide health services to the members of the PBCN residing in the communities of Southend, Pelican Narrows, Sturgeon Landing and Deschambault Lake, and anyone requiring emergency services while in the vicinity of the community which had a health center operated by PBCN Health.<sup>2</sup> This chapter provides an overview of the PBCN Health Transfer Agreement especially as it relates to the main governance themes of power/authority, accountability, relationships and political culture. It will cover the pre-transfer period, the mission and goals of the Transfer, and the main roles and responsibilities of PBCN Health Services Inc., the PBCN Chief and Council, and Medical Services Branch of Health Canada (MSB) as key signatories of the Agreement. This general knowledge will help provide a better understanding for the discussions in the next few chapters with respect to the experiences of the PB Health Board in implementing the Transfer, the decisions they made and the relationships they established with their key stakeholders.

There were 4 phases to the Transfer process outlined by MSB.<sup>3</sup> This chapter is mostly concerned with the pre-transfer period that is generally described in the first 2

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<sup>1</sup> PBCN Health Services Inc., Pamphlet entitled, "Peter Ballantyne Cree Nation Health Services Transfer: Working Together Towards Healthy Families and Communities," Prince Albert, Sask: 1995

<sup>2</sup> PBCN, PBCN Health Services Inc., Minister of National Health and Welfare Canada, The PBCN Health Transfer Agreement, 1995, PBCN Health Services Inc.: Prince Albert, Sask.: March 17, 1995, s.6

<sup>3</sup> Health Canada, Transferring Control of Health Programs to First Nations and Communities: Handbooks 1, 2, 3, Program Policy, Transfer Secretariat and Planning Directorate, Medical Services Branch, Health Canada, Ottawa: March 1999



phases. The 3<sup>rd</sup> or implementation phase is covered in the later chapters. The phases were as follows:

1. Pre-transfer planning phase. This involved the submission of a Band Council Resolution (BCR) to MSB initiating the transfer process and entering into negotiations for pre-transfer funding with them, the completion of a comprehensive community health needs assessment, the development of a community health plan with a proposed management structure along with program and service delivery plans.
2. Bridging Phase. The continuing development of the community health plan, creation of a Memorandum of Understanding (MOU) with Health Canada based on the findings of the needs assessment.
3. Implementation Phase. The 6 month transition phase started with the signing of  
 the Transfer Agreement on March 17, 1995, which required the Health Board to complete the community health plan, set up the organization, and take over the supervision of the existing MSB and Band health staff. The Board had a deadline to get all the preparatory work done by September 1995 at which time they would officially take over the management and delivery of all health services and programs to the PBCN communities identified in the Agreement.
4. Additions. This referred to the transfer of additional specialized services.<sup>4</sup>

#### **The PBCN Health Transfer Agreement**

The key players or signatories to the PBCN Health Transfer Agreement included the PBCN Health Services Inc., the PBCN Chief and Council and MSB,

<sup>4</sup> PBCN Chief and Council, Band Council Resolution, August 3, 1994, Pelican Narrows Sask.: 1994

Health Canada.<sup>5</sup> The wording in the Transfer Agreement reflected the broad objectives of the Federal Health Transfer Policy, and these were essentially to enable First Nation Bands such as PBCN to control and manage their own health services within certain parameters such as ensuring the delivery of mandatory health services to the communities and strengthening the accountability of the Band's health services to the membership.<sup>6</sup>

The general contents of the Transfer consisted of a 3 page preamble of "whereas" clauses setting out the general understandings and purpose of the Agreement and continuing with the provisions dealing with mandatory and other health program requirements, reporting expectations, financial terms and ending with attached appendices describing transferred inventory in the facilities, continuing responsibilities of the Minister, budgets and cash flow forecasts.

The \$17.5 million funding allocated under the Agreement to PBCN was to be managed for the use and benefit of the Band's members, and was strictly for the purposes of "funding health programs and services," and in administering these health funds, the Band could utilize their own corporations as trustees or otherwise, to act on their behalf in discharging their responsibilities under the Agreement.<sup>7</sup> The level of program funding under the Agreement was based on population formulas used by MSB in its Community Workload Increase (CWIS) for 1994-1995; and it was basically a complicated formula comprising information gathered from nursing

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<sup>5</sup> PBCN, PBCN Health Services Inc., Minister of National Health and Welfare Canada, The PBCN Health Transfer Agreement, 1995, PBCN Health Services Inc.: Prince Albert, Sask.: March 17, 1995

<sup>6</sup> PBCN, PBCN Health Services Inc., Minister of National Health and Welfare Canada, The PBCN Health Transfer Agreement, 1995, PBCN Health Services Inc.: Prince Albert, Sask.: March 17, 1995, 2

<sup>7</sup> *ibid.* s. 18

daybooks which tried to describe the number of hours nurses spent doing specific programs per day, per year, plus some other factors such as the size of the health center facility and so forth. The CWIS formula was used to determine the funding made available to each community with respect to staffing and other program needs. While the PBCN did not agree that with the accuracy of the population figures used in the formula, they agreed to their use for the purposes of the Agreement.<sup>8</sup>

The Transfer Agreement was described as an administrative contract for the performance of a service or program and that PBCN Health Services was an "independent contractor" engaged in the sole purpose of providing a service or program and responsible for all complying with federal and provincial laws relating to non-profit organizations.<sup>9</sup> The primary political authorities and signatories were the PBCN Chief & Council and Minister of Health Canada (MSB). The Agreement, however, was that the Minister and PBCN agreed that the "delivery, administration, provision, and control of health services by the Band" would be "assigned to the PBCN Health Services Inc., which undertook to perform all requirements of the Agreement in respect of the "delivery, administration, provision an control of health services."<sup>10</sup>

### **Transfer Negotiating Team**

Prior to the creation of the PBCN Health Board and the organization, the PBCN Chief and Council appointed a Transfer negotiation team consisting of 2 staff,

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<sup>8</sup> *ibid.*, s.5

<sup>9</sup> PBCN, PBCN Health Services Inc., Minister of National Health and Welfare Canada, The PBCN Health Transfer Agreement, 1995, PBCN Health Services Inc.: Prince Albert, Sask.: March 17, 1995, s.55

<sup>10</sup> PBCN, PBCN Health Services Inc., Minister of National Health and Welfare Canada, The PBCN Health Transfer Agreement, 1995, PBCN Health Services Inc.: Prince Albert, Sask.: March 17, 1995, s.3



legal advisors and 2 Portfolio Councilors to enter into health transfer negotiations with MSB. The Transfer negotiation team was responsible for completing the preparatory planning and development work necessary in the pre-transfer planning and bridging phases. The efficiency and expertise of the team enabled PBCN to speed up the transfer process. They were able to complete the technical components required in the first 2 phases ahead of schedule and what should have taken close to 2 years to complete (12 months for phase 1 and 9 months for phase 2), was actually done in less than a year. A new organization was then set up under the governance of a community- representative Board of Directors who were then able to sign as one of the parties to the PBCN Health Transfer Agreement, along with the PBCN Chief and Council and MSB. The Board continued to rely on the Transfer team throughout the transition period and on a more permanent basis afterwards through various business arrangements, including the hiring of several of the team members, all of which helped provide support and continuity with respect to corporate knowledge and administrative expertise.

#### **Pre-Transfer Community Needs Assessments**

The PBCN Chief and Council were given political approval through a Band Council Resolution to initiate Pre-Transfer proceedings and by April 1990, they signed a Health Pre-Transfer Agreement with MSB. This step provided funding to conduct a comprehensive community health needs assessment and to develop a community health plan for the seven northern Band communities of Pelican Narrows, Deschambault Lake, Southend Reindeer Lake, Sandy Bay, Denare Beach, Kinoosao and Sturgeon Landing. While PBCN officially represented eight communities, the

urban reserve in Prince Albert was not included at the time of survey due to its designation as a commercial rather than residential reserve. The community needs assessment examined the services provided out of the four MSB nursing stations situated in Pelican Narrows, Southend, Deschambault Lake and Sturgeon Landing, including the Band administered services operating in these communities and the non-MSB nursing station communities in Sandy Bay, Denare Beach, and Kinoosao. These non-MSB nursing stations were technically off-reserve and under provincial management. However, all were under the Treaty Land Entitlement process which would make them reserves at some future point, and therefore eligible for Health Transfer, but they were not eligible at the time of survey.

The coordination of the needs assessment project was contracted out to several researchers with guidance and advisory support from the PBCN Chief and Council, PBCN administration staff, Prince Albert Tribal Council health staff, and MSB personnel from the Prince Albert Zone office.<sup>11</sup> The implementation of the door-to-door community surveys and local coordination of the survey were done by local researchers in their respective communities. This extensive community consultation process provided opportunities for community education with respect to the decision by PBCN to take over their health programs. In that sense, community people were made aware of the project and could provide feedback with respect to their opinions on whether the band should assume responsibility for healthcare services. Most communities indicated support for the takeover. In Pelican Narrows,

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<sup>11</sup> The Peter Ballantyne Cree Nation, from the "acknowledgment" sections of the Southend, Pelican Narrows, Deschambault Lake, and the combined Sturgeon Landing, Denare Beach, Sandy Bay Health Care Needs Assessment For The Members Of The Peter Ballantyne Cree Nation reports, Pelican Narrows: July 1991, prepared by Jackie Carter and Diane Martz.

for example, 56% said yes, 25% maybe and 16% said no.<sup>12</sup> In Southend, 70% said yes, 23% said maybe, and 7% said no.<sup>13</sup> In Sturgeon Landing, Denare Beach, and Sandy Bay, 79% said yes, 14% said maybe, 7% said no.<sup>14</sup> In Deschambault, 58% said yes, 33% said maybe, 9% said no.<sup>15</sup>

The methodology used consumer needs surveys, key informant questionnaires and interviews with key informants including nursing station staff, band staff and community leaders. Band level information came from population and vital statistics reviews, use of physician services from the Manitoba Health Services Commission, hospitalization patterns data from the Saskatchewan Hospital Services Plan, nursing station reports, health committee minutes, CHR, NNADAP, and other various program reports.<sup>16</sup>

After the needs assessments were done in 1992, comprehensive reports were made for each of the PBCN survey communities and an overall Community Health Plan was prepared from the combined results and completed in September 1994. The major health needs summarized in the Community Health Plan were as follows:<sup>17</sup>

- Environmental – improvements in garbage collection and disposal systems, water quality and sewer problems, and overcrowded housing conditions with only 24% having indoor plumbing facilities.

<sup>12</sup> PBCN, Health Care Needs Assessment For The Members of The Peter Ballantyne Cree Nation Living At Pelican Narrows, Saskatchewan, Pelican Narrows: July 1991, by Jackie Carter and Diane Martz., 126

<sup>13</sup> PBCN, Health Care Needs Assessment For The Members of The Peter Ballantyne Cree Nation Living At Southend, Saskatchewan, Pelican Narrows: July 1991, by Jackie Carter and Diane Martz., 107

<sup>14</sup> PBCN, Health Care Needs Assessment For The Members of The Peter Ballantyne Cree Nation Living At Sturgeon Landing, Denare Beach, and Sandy Bay, Saskatchewan, Pelican Narrows: July 1991, by Jackie Carter and Diane Martz., 88

<sup>15</sup> PBCN, Health Care Needs Assessment For The Members of The Peter Ballantyne Cree Nation Living At Deschambault, Saskatchewan, Pelican Narrows: July 1991, by Jackie Carter and Diane Martz, 119

<sup>16</sup> Peter Ballantyne Cree Nation, Community Health Care Plan, Prince Albert, Sask.: 1995, 1

<sup>17</sup> *ibid*, 2-6



- Socio-economic - revitalization of traditional spirituality and improvements in the high unemployment rates which in a 1987 economic survey were reported as being over 79% across all PBCN communities with the major employment coming from the band administration, the local stores, the RCMP, the nursing stations, and in some places mining. The seasonal employment came from fishing, forestry, trapping, wild rice harvesting, summer works projects, construction, fire fighting and guiding.
- Education – improved local educational facilities to deal with the low level of education.
- Recreation – the need for accessible recreation facilities were identified to give people something to do apart from outdoors recreation activities.
- Substance abuse – great concerns were expressed to deal with the prevalent alcohol, drugs, and other substance abuse problems in the communities, particularly with the youth.
- Family problems – improved programs and actions needed to deal with issues of child and elder neglect, family violence, poor parenting skills, sexual abuse, and the general poor state of physical, mental, emotional and spiritual health.
- Teen pregnancy – improved child-care facilities and programs in family planning were among the needs identified to deal with the high rate of teen pregnancies.
- Elder Care – improved and consistent care for elders was identified in terms of medical care, home care, better housing, nutrition, social activities, and more organized opportunities to interact with young people.
- Domestic Violence and Spousal Assault – the need for safe houses for victims was identified along with more funding for counseling programs to deal with high rates of domestic violence.
- Morbidity and Disease Control – the reports on the physician-hospital utilization trends indicated high sickness and injury rates in the PBCN population. High incidences were reported in respiratory illness, injuries, diabetes, gallbladder disease, hypertension, arthritis, thyroid disorders, recurring cases of tuberculosis, fetal alcohol syndrome and developmental delays in children. Concerns for more information on AIDS awareness were also identified.

### Political Culture and the PB Health Corporate model

The Chief and Council chose to structure the organization as a Non-Profit Corporation for a variety of reasons.<sup>18</sup> It provided them with a vehicle that was at arms length from the politics that was associated with the Band administration and yet still provided them with local control through a community Board. It also satisfied the issues of financial and management accountability that MSB wanted in the Transfer.<sup>19</sup> Significantly, under the Non-Profit Act, the surpluses of the organization had to be reinvested towards health programming rather than being distributed to members as dividends as they would for a profit-oriented organization.

Their decision was also influenced by the political culture of the PBCN communities where people were wanting more local control and involvement in political decision-making and because there were issues around the Band deficit situation, they were open to alternative ways rather than Band administration for administering and providing local services.<sup>20</sup> Repeated references in the pre-transfer needs surveys to "more control over our own lives and communities,"<sup>21</sup> "that the Band should be more responsive to the needs of their people than MSB would be,"<sup>22</sup> "that the healthcare should be more community-based,"<sup>23</sup> and that "local people should have more say into what they feel they want to see in their community,"<sup>24</sup> all

<sup>18</sup> PBCN Chief and Council, Band Council Resolution, July 14, 1994, Pelican Narrows Sask.: 1994

<sup>19</sup> Ibid, in the bottom "whereas,

<sup>20</sup> PBCN, Health Care Needs Assessment For the Members of The Peter Ballantyne Cree Nation Living at (Southend), (Pelican Narrows), (Deschambault Lake), (Sturgeon Landing, Denare Beach, Sandy Bay): August 1991, Pelican Narrows, Sask.: PBCN, 1991

<sup>21</sup> Ibid, Southend, 38

<sup>22</sup> Ibid, Sturgeon Landing, Denare Beach, Sandy Bay, 31

<sup>23</sup> Ibid, 69

<sup>24</sup> Ibid, Pelican Narrows, 42

reflected the general sentiment for a more responsive, accountable and accessible health delivery system.

This desire by the PBCN people for their own community healthcare system was also consistent with their traditional political culture that tended to view authority in terms of service and responsibility, rather than hierarchical power and management. They wanted more direct access to decision-makers and service providers. The care of individuals had been considered a cooperative responsibility within the historical PBCN family and extended family networks, and while some individuals may have had special healing gifts in diagnosis, herbal medicine, midwifery and other skills, health care had not been isolated to these individuals. The communal nature of Woodland Cree hunting and trapping societies from which the PB people descended, were well described by scholars as consisting of family social units or households usually headed by male patriarchs or fathers.<sup>25</sup> The basis of the traditional paternal authority was flexible. The normal functioning of the households required every one, including children and elders, to work together.

The communal and highly personalized approach to health care in the past was not isolated to healing, but could be found in all aspects of their traditional way of life. According to historical depictions of northern pre-contact societies, terms such communal, consensus decision-making and direct citizen involvement,<sup>26</sup> extended

<sup>25</sup> See Chapter 3 of thesis. Also, Buckley, Helen and J. Kew, John Hawley, The Indians and Metis of Northern Saskatchewan: A Report on Economic and Social Development, Saskatoon, Sask.: Centre for Community Studies, 1963; also, Ballantyne Phillip, et.al., Aski-Puko: The Land Alone, A Response to the Proposed Hydro-Electric Installation at Wintego Rapids by The Cree of Peter Ballantyne and Lac La Ronge Bands, Saskatoon, Sask.: Office of the Treaty Commissioner, 1976; also Brightman Robert, Grateful Prey: Rock Cree Human-Animal Relationships, Berkeley and Los Angeles, California: University of California Press, 1993.

<sup>26</sup> Cassidy Frank, Robert L. Bish, Indian Government: Its Meaning in Practice, Lantzville, B.C. Canada: Oolichan Books and the Institute for Research on Public Policy, 1989, 77-78;



kinship groups,<sup>27</sup> collective ownership, equal access,<sup>28</sup> sharing among family households, kindness, assistance, cooperation, respect, hospitality,<sup>29</sup> among others, described the communal, personalized nature of northern life. Some further suggest that in spite of the many changes and colonial influences, these informal and non-hierarchical values have by and large endured into the present day.<sup>30</sup> In the case of PBCN, the desire for a more responsive and personalized approach to medical care, may have been indicative of the resilience of some of these traditional values,<sup>31</sup> or it could simply have been a response to the lack of support services in the communities, or both, but in any event, what is evident is that the political environment that the PBCN Health Board was going to be faced with in the communities was communal oriented, personalized and distinguished along family and kinship lines and the health system they had to develop had to be seen as being fair, open and accessible to everyone, regardless of family and political connections.

While it is unclear what extent and in what ways PBCN cultural history might have influenced the development of the PB Health organization and Board, it was

<sup>27</sup> Boldt Menno, Surviving as Indians: The Challenge of Self-Government, Toronto: University of Toronto Press, 1993, 118-119

<sup>28</sup> Leacock Eleanor and Richard Lee., Politics and History in Band Societies, Cambridge University Press, 1982, 8, 9

<sup>29</sup> Ballantyne Phillip, et.al., Aski-Puko: the Land Alone, Saskatoon: Office of the Treaty Commissioner, 1976, 5, 6; also, Ron Merasty, A Portrait of the Peter Ballantyne Cree Nation, in "Traditional Cree Culture, Part 2: Cree Cultural Traits, Prince Albert, Sask.: , unpublished historical writings, 9; also in Robert Brightman E., Grateful Prey: Rock Cree Human-Animal Relationships, Berkeley and Los Angeles, California: University of California Press, 1993, 10; also Helen Buckley and J. Kew, John Hawley, The Indians and Metis of Northern Saskatchewan: A Report on Economic and Social Development, Saskatoon, Sask.: Center for Community Studies, 1963, pg

<sup>30</sup> Calliou Sharilyn, "Activism and Self-Determination in First Nations Education (1972-1998)" in John H. Hylton (ed), Aboriginal Self-Government in Canada: Current Trends and Issues, Saskatoon, Sask.: Purich Publishing Ltd., 1999, 161; also, Harold Cardinal & Walter Heldebrandt, Treaty Elders of Saskatchewan: Our Dream is That Our Peoples Will One Day Be Clearly Recognized as Nations, Calgary, Alberta: University of Calgary Press, 2002

<sup>31</sup> PBCN Health Services Inc., PBCN Health Transfer Evaluation, August 1996, " Prince Albert, Sask.: PBCN Health Services Inc., 1996, 11

clear that the PBCN people wanted a healthcare delivery system that they could better relate to and which offered improved services. The political environment during the 1990-1995 Transfer period challenged the PBCN leadership on various fronts in terms of getting approvals for any major agreements. The growing PBCN administration deficit and difficult land entitlement negotiations had raised credibility and accountability issues in the communities as well as with outside government funding agencies. These factors among others helped to build political support for the concept of setting up an autonomous health organization or NGO<sup>32</sup> governed by a board of community representatives with the PBCN political leadership holding monitoring and advisory functions. The general idea was to separate politics from administration especially in the area of providing essential services such as health. The direct provision of health funding to the NGO was seen as a way of facilitating a more focused approach to health programming and delivery and a means of protecting health funding from being diverted to other non-health related purposes.

These developments in the Transfer process changed the nature of the PBCN Health Transfer Agreement from the more common bilateral (Band council-MSB) agreement to a tripartite agreement between the PBCN Band council, MSB, and the new NGO, PBCN Health Services Inc. While the NGO idea was generally supported by the majority of political leadership, there were concerns that the transfer of certain powers and authority from an elected political government to a board of community representatives could lead to an erosion, or as some state scholars would say, "the

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<sup>32</sup> Non-government organization

hollowing out" of the political powers of the central government<sup>33</sup> which in this case could potentially have board authorities competing with the political authority of the Band government.

At the time, the leadership was preoccupied with managing controversies over financial issues and requirements by Indian Affairs to produce remedial management plans to deal with the deficit problems which were affecting many programs. General public mistrust of the political leadership and the centralizing tendencies of the Band administration was growing and raising credibility and capacity issues in the communities. The move to take over more community programming especially in such a crucial area as health services was met with skepticism by many who felt that the existing Band administration did not have the capacity to assume more responsibilities and they were afraid of losing whatever health services they had. While they were not satisfied with the fragmentation of services provided by MSB and the tribal council, they were uncertain of how much better the services would be under Band administration.

The other issue that affected the Health Transfer process was political problems associated with getting community support to sign the 1992 Saskatchewan Treaty Land Entitlement Framework Agreement that would settle all the Band's outstanding land entitlements under Treaty. As far back as 1976, the Band had participated with their larger political affiliates in negotiating with the federal and provincial governments over the issue of settling outstanding land claims. The leadership was prepared to sign the TLE agreement, but in their community

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<sup>33</sup> Theda Skocpol and Kenneth Finegold, *Political Science Quarterly*, et.al., (1982), Jon Pierre, *Debating Governance* et.al., (2000), Mark Turner, David Hulme, *Governance* et.al., (1997), E.H. Fry, *The Expanding Role of State* et.al., (1998), Marsh and Rhodes, *Policy Networks* et.al., (1992)



consultations they met with both support and resistance from prominent individuals and families who had coalesced into "yes" and "no" divisions. One side wanted to sign and get on with the business of developing their communities through the provisions offered in the agreement for reserve creation and other socio-economic development opportunities. The other side opposed the signing because of fears of losing their treaty rights, such as water rights among others, and problems with specific terms of the Agreement, such as the cash provision to buy back provincial lands for reserve creation which they felt should just be transferred over for free according to their understanding of Treaty. The impact of the TLE process also affected the Transfer process in the sense of having to build the health system on an already volatile political environment and a political culture characterized by a division in the PBCN membership regarding federal agreements like TLE, questions about the legitimacy and financial credibility of the Band leadership and administration, and feelings of not having real community input into Band decisions.

The PBCN Health Services Inc. was set up as a registered company under the Non-Profit Corporations Act of Saskatchewan in March 1995. Its incorporation as a non-profit agency, while subject to many factors, could probably be most attributed to trying to secure health funding for health purposes and not "to any other Band program or for other Band operations."<sup>34</sup> The concerns with the financial deficit situation of the Band Administration by both the Chief and Council and MSB was such that both parties wanted to create a separate health organization apart from the Band administration, and consequently, through a series of Band Council

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<sup>34</sup> The PBCN Health Services Inc., clause 17 (1) of the "PBCN Health Services Transfer Agreement," Prince Albert, Sask.: 1995, 12

Resolutions, the Chief and Council delegated the management, administration and financial control of all their health care services and programs to the PBCN Health organization and Board.<sup>35</sup>

### **The PBCN Community Health Care Plan**

The PBCN Community Health Care Plan (CHP) acts as the primary guiding document for the organization and the basis for the strategic policy direction later developed by the Board in the PBCN Health Directional Plan. It outlines the goals and vision of the proposed PBCN health care system, how it should be governed and administered, the management structure and staffing, budget, reporting requirements, a description of the mandatory and other health programs and services to be delivered, a training plan, confidentiality guidelines with respect to health records, insurance coverage, emergency response planning and an evaluation process. It was evident that the plan was to set up an autonomous non-profit health Board and organization to implement the Agreement. The governance section stated: "After further consideration and consultation, the PBCN Council decided, that in the best interests of the Cree Nation, the management and control for health services and programs should be community based and under the control of the PBCN Council through the Health Board."<sup>36</sup> This decision was most likely in response to the political environment of the time as well as the findings in the community surveys which identified the need for more local control and input, to have more trained personnel providing culturally appropriate and responsive services, more help for individuals to gain responsibility over their own health and that of their families, and to have health

<sup>35</sup> PBCN, PBCN Band Council Resolutions, dated July 14, 1994, January 26, 1995, March 17, 1995; Prince Albert, Sask.

<sup>36</sup> Peter Ballantyne Cree Nation, Community Health Care Plan, Prince Albert, Sask.: 1995, 4, 5

become a policy priority for the band. The reasons cited by those surveyed who did not want Transfer mostly had to do with doubts about the inability to do the job right and the lack of appropriate leadership and personnel.<sup>37</sup>

The kind of health system that the communities desired went beyond the desire for better quality medical services to include the development of a wide array of support programs that would work towards building sound mental, emotional and spiritual health along with the provision of a safe physical environment for the individuals and families in the communities. The PBCN Community Health Plan that basically described the goals and purpose of the Transfer described this holistic view towards health in terms of "a general state of total well-being and effective functioning rather than just an absence of physical illness."<sup>38</sup> The primary goal therefore was to build a sustainable community-based health system in each of the four Transfer communities based on values of "balance, of wholeness, of optimum well-being and of the realization of all of one's potentialities."<sup>39</sup> The guiding principles or values of the organization were:

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<sup>37</sup> The Peter Ballantyne Cree Nation, from the "major service gap" sections of the Southend, Pelican Narrows, Deschambault Lake, and the combined Sturgeon Landing, Denare Beach, Sandy Bay Health Care Needs Assessments For The Members Of The Peter Ballantyne Cree Nation reports, Pelican Narrows: July 1991, prepared by Jackie Carter and Diane Martz.

<sup>38</sup> PBCN, PBCN Community Health Care Plan, January 1995, PBCN Health Services Inc., Prince Albert, Sask.: 1995, 9

<sup>39</sup> PBCN, The PBCN Community Health Care Plan, Pelican Narrows, Sask.: January 1995, 7



1. "That Indian people must have equal access to health services of the same range and quality as is available to the rest of the province.
2. That PBCN Health Services must incorporate the holistic approach to meet the individual, family and communities' spiritual, cultural and social needs;
3. That cooperation with other health delivery systems shall be ongoing on an equitable basis for the benefit of all;
4. That it is the right of Indian people to determine their own needs and to design and control a health delivery system to meet their needs."<sup>40</sup>

The purpose or mission statement was:

"To provide and facilitate a holistic health service that promoted physical, mental, emotional and spiritual wellness to its members in the communities of Pelican Narrows, Deschambault Lake, Southend and Sturgeon Landing."<sup>41</sup>

The concept of what was meant by these holistic services was made clearer at an orientation conference that the Board held during the transition phase prior to taking over the actual control of all health services. During the course of the discussions, a picture of a calm northern lake with trees and hills was used as a metaphor for what the Board desired their communities to look like – peaceful and safe – just like they used to be before all the problems associated with alcohol and drug abuse dominated their lives.<sup>42</sup> In other words, PBCN Health was expected to help people deal with these problems in their communities by developing a wide range of health services from the 24-hour, year round medical treatment services, health education, counseling and other addiction support services which were

<sup>40</sup> PBCN Health Services Inc., Directional Plan, Prince Albert, Sask.: PBCN Health Services Inc., 7

<sup>41</sup> PBCN Health Services Inc., Directional Plan, Prince Albert, Sask.: PBCN Health Services Inc., 4

<sup>42</sup> PBCN Health Services Inc., Transfer of Health Services, Presentation paper, PBCN Health Services Inc., Prince Albert, Sask.: 1999; and from my own personal notes from that conference.

required by the Transfer Agreement and to expand beyond these to develop new projects and programs designed to support and help individuals, children, youth, elders and families improve their quality of life within safe environments.

While the holistic approach was not clearly defined in the Community Health Plan, there were references to the integration of treatment and prevention services that would incorporate all aspects of mental, physical, emotional and spiritual health. The philosophy was that health programs needed to take into account the full spectrum of First Nation society starting with the individual, the family and the community. A balanced health system in this view would have a society manifesting characteristics such as competence, capability, internal focus of control, a sense of power and control over one's future, a sense of boundary and self-limit, sense of purpose and future, clear values, good sense of judgment and problem solving skills, high self esteem, sense of self worth, sense of responsibility, caring and duty of others.<sup>43</sup>

The Community Health Plan also provided a list of programs, objectives, activities and evaluation measures that would comprise the "bare bones" of the proposed PBCN health delivery system.<sup>44</sup> The programs included community health education, nursing, communicable disease control, environmental/occupational health, dental, mental health services, NNADAP, Parenting and family planning, and elder care and home care. An organizational and management structure was set up to establish the coordination of policy, management and service delivery functions of health services. The Board would be responsible for the overall policy direction and administration of the organization. The local health committees would continue to

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<sup>43</sup> PBCN Health Services Inc., *Transfer et.al.*, *ibid*, 9

<sup>44</sup> *ibid*, 12 - 21

function as local policy and planning support for the Board members and the health clinic administration. It was expected that the role of the health committees would be stronger under the Transfer Agreement with the inclusion of the local Board representatives and political representation from the Health Portfolio Councilors and ex-officio standing of the Chief in the committees.

The role of the health staff was to implement the terms of the Agreement according to the governing directives of the Board. The management was responsible for the overall coordination of the programs and services being delivered in the communities as well as reporting to the Board and chief and council on a regular basis for program updates. The management positions included an executive director, an executive clerk, program directors in Finance and Personnel, Community Development, Nursing, Nursing Supervisor and in the communities, local health coordinators were to be hired to administer the health clinics along with support from nursing managers and other program staff such as the community health representatives.<sup>45</sup>

#### **Board Governance and Authority**

The incorporation authorized a board of directors with legal standing to sign as the third member in the tripartite Health Transfer Agreement between PBCN and MSB, and enabled them to receive and administer public funds. The power and authority of the Board to manage the terms of the Transfer Agreement were delegated from the PBCN Chief and Council through a Band Council resolution. The Board consisted of ten members who were elected by chief and council and ratified through a Band Council Resolution. While the Transfer Agreement only involved the

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<sup>45</sup> PBCN Health Care Plan, *ibid.*, 27



provision of health services to the four reserve communities, the Board membership included representation from the non-transferred communities as well. The larger reserve communities of Pelican Narrows, Deschambault and Southend had two representatives, the small community of Sturgeon Landing had one representative, and the non-transferred communities of Sandy Bay, Denare Beach and Prince Albert also had one representative. The small community of Kinoosao was represented through the Southend group.

The governance of the Board was structured around the legal framework and specific duties, powers, responsibilities and accountabilities required of board members in the Non Profit Corporations Act with specifics identified in the corporation's bylaws. The Board had the authority to create bylaws with respect to internal matters such as the structure of the organization and terms of election but these were subject to the approval of the Chief and Council as members who had a duty to ensure that the Band membership was getting the health services identified under the terms of the Health Transfer Agreement. The standard of care required by the Board in discharging their duties was to act honestly and in good faith for the best interests of the organization and to exercise the due diligence, care and skill required of a reasonable person in comparable circumstances.<sup>46</sup>

A system of checks and balances on Board authority against potential misuse or abuse of power associated with the official standing was also provided. Although the authority of the Board covered the entire management of the organization, it was limited to policy functions with the day-to-day operational duties assigned to

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<sup>46</sup> Nahachewsky, Carl M., legal counsel for PBCN Health, in a document entitled, Peter Ballantyne Cree Nation Health Services Inc., Executive Summary, PBCN Health Services Inc., September 17, 1998, 1

employees. While the Board was recognized as the "controlling mind and policy makers of the corporation," they did not have the responsibility or duty for "day to day operations of case loads," which were staff and employee functions.<sup>47</sup> There were also conflict of interest provisions that required that individual Board members would remove themselves and not vote in cases where they had a perception that they could get personal gain, either monetarily or in some other way.

While the parameters of the legal authority of the Board were provided in the incorporation documents, the governance and policy functions and responsibilities in the health organization were outlined in the PBCN community health plan. The primary expectation of the Board was to work towards developing a new health care system that would integrate both treatment and prevention services within a holistic, community-based model of healing and well-being.<sup>48</sup> The Board was given the flexibility to determine how this process would be carried out, but a framework of generalized tasks and duties was also provided to help their developmental planning. These included: determining the structure of local control; the formation, composition and power of local committees; mapping out how the different sectors would be coordinated and their accountability; deciding on the distribution of resources; deciding which programs and services to deliver; identifying the training needs and developing training programs; identifying the equipment, supplies and physical facilities needed; and establishing the necessary social, managerial, technical guidance and supervision from internal and external sources.<sup>49</sup>

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<sup>47</sup> *ibid*, 2

<sup>48</sup> PBCN Community Health Care Plan, *ibid*, 26

<sup>49</sup> *ibid*, 26

To meet the mission and goals of Transfer, the Board was provided with a broad range of governing powers from planning, policy-making, administering and being able to enter into agreements with other agencies. In that sense, successful governance for them meant the responsible use of their authority in these areas in meeting these goals.

PB Health was responsible under the Agreement for delivering, administering, providing and controlling health services through the guiding objectives and activities described in the PBCN Community Health Care Plan.<sup>50</sup> The Board as the directors of PB Health was responsible for ensuring that PB Health was being administered properly according to the terms of the Agreement, including such things as having proper insurance coverage in the event of any potential medical malpractice and professional liability. There was some flexibility such as the ability to transfer surplus program funds to other health programs and services as long as the mandatory program requirements were met, but on the other hand, PB Health was also liable for any operating deficits. One of the clear limitations was that Transfer funds could not be transferred to any other Band administered programs or for other Band operations.<sup>51</sup> In terms of ensuring accountability, the Board had to provide independently audited annual financial statements in compliance with general accounting principles,<sup>52</sup> and program performance reports of PB Health through an annual report which was then to be made publicly available to Band members and MSB.

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<sup>50</sup> PBCN, PBCN Health Services Inc., Minister of National Health and Welfare Canada, The PBCN Health Transfer Agreement, 1995, PBCN Health Services Inc.: Prince Albert, Sask.: March 17, 1995, s.4(1)

<sup>51</sup> *ibid.* s.17

<sup>52</sup> PBCN, *op.cit.*, s.31, 32



PB Health was also required to ensure confidentiality of any information of a confidential nature relating to the affairs of the parties under the Agreement, and in accordance with the provisions of the Access to Information Act. This was particularly in reference to personal medical information to which PBCN Health staff had access and was required to treat as confidential according to the protections in the Privacy Act.

There was also a provision to set up a service implementation and monitoring committee for the first year of the Agreement for the purposes of reviewing the annual report, population issues, capital issues and other related health service issues. The monitoring committee consisted of the PB Health Chairperson, Executive Director, Assistant Executive Director, Finance Director and the MSB north zone (PA) director, nursing officer and the MSB Regional Program Transfer Manager (Regina). In actual practice, the committee was kept informal with meetings called as needed.

The health programs that PB Health was required to implement under the Agreement included:<sup>53</sup>

1. Community health services provided by Community health representatives (CHRs) or Community health developers (CHDs) as referred to under PB Health to refer to their expanded functions in health education and program coordination apart from their previous roles as assistants to nurses and Cree interpreters.
2. Community alcohol and drug abuse services (NNADAP program)
3. Health education services

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<sup>53</sup> *ibid*, s.4

4. Moveable capital assets (supplies and equipment)
5. Health Services management & administrative activities
6. Operation and management of health center facilities, including nurses' residences (by July 1, 1995); the accountability required of PBCN Health in managing the buildings was one of a prudent caretaker.<sup>54</sup>
7. Community health nursing services and nursing professional supervision (by September 1, 1995)
8. Mandatory programs such as the Communicable Disease Control - Immunization and TB control including contact tracing and follow-up which generally would be monitored by the Medical Health Officer (MHO) contracted by MSB; Treatment Services, and Environmental Health services provided through an Environmental Health Officer (EHO) contracted by the Prince Albert Grand Council on behalf of PBCN.
9. That PB Health would contract with a pharmacy to purchase the required supplies of stocked drugs and medical supplies in the health centers and that these expenditures would be controlled separately and reported in the annual audit; and that the regulations in the Narcotic Control Act, Criminal Code and the Food and Drug Act would be followed.<sup>55</sup>
10. With respect to evaluation, PB Health had to develop an evaluation plan in the first year, and conduct the evaluation on the effectiveness of its community health programs in the final year.<sup>56</sup>

#### **Chief & Council Authority & Responsibilities**

<sup>54</sup> PBCN, op.cit., s.20

<sup>55</sup> ibid. s. 12

<sup>56</sup> PBCN, op.cit., s.35

The duties and responsibilities of the PBCN Chief and Council under the Agreement were primarily to select the Health Board, approve the Bylaws for the organization, provide advisory support and political advocacy to PBCN Health to ensure compliance with the terms of the Agreement and to monitor the continuing federal responsibilities of the Minister of Health with respect to Indian health. The Agreement had specific terms that "nothing in this Agreement" would "diminish, derogate or prejudice any treaty or aboriginal rights of the Band or its members," or any potential future claims to land and self-government. The PBCN Chief and Council had been wary of the administrative contractual nature of the Transfer Agreement, and wanted some assurance that the terms in Agreement would not in any way be construed as affecting or modifying their interpretation of the Treaty rights to health as mentioned in the "medicine chest" provisions of Treaty 6.<sup>57</sup>

Unlike other Transfer Agreements, there were also specific provisions acknowledging that the Minister was aware that PBCN was undergoing Treaty Land Entitlement processes which could lead to the creation of new reserves and thus affect the delivery of health services, and the Minister agreed that his staff would work with the Band in addressing the delivery of health services to these potentially new reserves.<sup>58</sup>

The delegation of responsibility in the Agreement from the Minister of Health to the PBCN Chief & Council and the subsequent assignment of that responsibility to the PBCN Health Services Inc., was therefore understood by the parties to be administrative in nature and not in any way connected to settling Treaty claims to

<sup>57</sup> *ibid.*, in the preamble "whereas" clauses, 3

<sup>58</sup> The Minister of National Health and Welfare, The Peter Ballantyne Band, The PBCN Health Services Inc., The Health Service Transfer Agreement, 1995, Prince Albert, Sask.: 1995, s.2(1)(2)



health, and that the terms of the Agreement were limited to the "delivery, administration, provision and control of health services."<sup>59</sup>

As trustees of the PBCN membership, the Chief and Council held the political and legal authority and responsibility to elect the Board of Directors and approve the Bylaws for the health organization.<sup>60</sup> Each of the health portfolio councilors from the ten communities recommended their representative(s) to the Band Council for approval. According to the health organization bylaws which determined the internal corporate structure and terms of elections for the Board,<sup>61</sup> the directors had to be 18 years old or over, resided within the noted communities, had knowledge about the health transfer process, knowledge about local health issues, been a positive role model and had been involved in community activities.<sup>62</sup> These individuals were then given formal Chief and Council approval through a Band Council resolution (BCR), which is a process required for most federal funding agreements as evidence of the political approval of the First Nation government.<sup>63</sup>

Other provisions in the bylaws included terms of election, conflict of interest, ex-officio members, and tenure of directors, financial responsibilities, and quorum meeting guidelines, structure, removal provisions and internal committee structures.<sup>64</sup>

<sup>59</sup> *ibid.*, s.3

<sup>60</sup> PBCN Health Services Inc., PBCN Health Services Inc., Executive Summary, Prince Albert.: Sept 17, 1998 in a legal information document to PBCN Health by Legal Counsel, Carl. M. Nahachewsky

<sup>61</sup> *ibid.*, 3

<sup>62</sup> PBCN Health Services Inc., PBCN Health Services Incorporated Bylaws, Prince Albert, Sask.: 1995,

<sup>63</sup> Health Canada, Transferring Control of Health Programs to First Nations and Inuit Communities, Handbook 2: The Health Services Transfer, Ottawa: Program Policy, Transfer Secretariat and Planning Directorate, Medical Services Branch, 1, criteria for pre-transfer planning; also in Carswell, Thomson Professional Publishing, Consolidated Native Law Statutes, Regulations and Treaties, 1994, Scarborough Ontario, Thomson Canada Limited, 1993, 54-57 outlining Indian Band Council Procedures

<sup>64</sup> PBCN Health Services Inc., PBCN Health Services Incorporated Bylaws, Prince Albert, Sask.: 1995, 1-5

The initial terms for the Board members were staggered one and two year appointments with five directors being appointed to one-year terms and five to two-year terms. Following that initial stage, all appointments thereafter would be two years. The directors could be reappointed for three consecutive terms, and after that, be eligible for reappointment for one year.<sup>65</sup> This was to ensure that there would always be a blend of experienced and new Board members governing the corporation in the future for capacity and continuity reasons. In cases where the Board member vacated the position through resignation, death or removal according to corporate bylaws, the Chief and Council could appoint a replacement for the duration of the term of that position.

The conflict of interest provisions indicated that no director could be a Chief or Councilor or a health staff member. This was aimed at separating the political system from the administrative governance of health services and keeping personal interests at an arms length from the operations of the health organization. The continuing role of the Chief and Council in the Board system, however, still remained through the advisory, non-voting, ex-officio memberships of the Chief and health portfolio Band Councilors. While some communities raised administrative issues with respect to the viability of having staff from other band agencies, such as education, sitting on the health Board, the practice was generally to keep the eligibility open. The concerns had to do with time spent away at meetings and the need for compensating the employer agency for replacement workers, and these were later resolved with various forms of compensation by the health organization.

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<sup>65</sup> PBCN Health Services Inc., PBCN Health Services Incorporated Bylaws, Prince Albert, Sask.: 1995, 1

### Chief and Council Relations<sup>66</sup>

With respect to the ongoing political relations between the Board and Chief and Council, the Band adopted the portfolio system which was the accepted practice used by most PBCN local boards and committees. It was also a common practice among other Bands in Canada. In the portfolio system, Band Councilors are assigned specific program portfolios such as health and education and as Portfolio Councilors, are mandated to work with their respective program committees and boards.<sup>67</sup> The advantages to the portfolio system have been described as an efficient means for organizing the political and administrative division of labor amongst the councilors, enabling greater training opportunities for councilors to become skilled in certain service areas, and giving elected officials greater control in influencing the services to move towards the political direction of the band government. On the other hand, the disadvantages included tendencies to overload Councilors or program authorities with too many responsibilities thus resulting in inefficiencies and isolating programs from one another and inhibiting cooperation.<sup>68</sup>

The PB health organization experienced a measure of both. Although the authority of the Health Portfolio Councilors was limited to an advisory and advocacy nature, they were expected to attend all the Board meetings and served as the primary communication link between the Board and Chief and Council. They were ultimately held responsible for ensuring that health services were being delivered properly and

<sup>66</sup> PBCN Health Services Inc., *Directional Plan*, Prince Albert, Sask.: PBCN Health Services, 1995

<sup>67</sup> Cassidy Frank, ed., *Aboriginal Self-Determination*, Lantzville, British Columbia: Oolichan Books and the Institute on Public Policy, 1991; also, Anderson Robert Brent, *Economic Development Among The Aboriginal Peoples in Canada: The Hope For The Future*, North York, Ontario: Captus Press Inc., 1999

<sup>68</sup> Cassidy Frank, Robert L. Bish, *Indian Government: Its Meaning in Practice*, Lantzville, British Columbia: Oolichan Books and the Institute on Public Policy, 1989, 84, 85 and Cassidy Frank, op.cit., ibid, 266-267;



in accordance with the political direction of the Band.<sup>69</sup> On the downside, the Portfolio Councilors also had busy schedules with their own local administration responsibilities and on a regional Band level, were often balancing multiple portfolios that often resulted in not being able to attend Board meetings and not being properly informed. With a Band the size of PBCN, this was almost inevitable, and in trying to balance the regional interests and community politics, portfolios were assigned in various ways. Some were grouped along similar social program areas such as Health and Indian Child and Family Services and others along the specific skills or interests of the Councilors. In trying to organize their workloads and responsibilities, the Board had been requested by the Portfolio Councilors to arrange their Board meetings so that they would not conflict with the schedules of the other organization(s). However, this was not always possible.

This portfolio system was carried over to the Band's practice for appointing elders to serve as advisors to the various Band programs and services. PB Health appointed an elder to serve in an advisory capacity to the Board, whenever requested, on matters pertaining to the proper functioning of the health organization. While the role of the elder was generally described as advisory in the Community Health Plan, there was a general understanding that he/she would also follow the code of ethics that governed the general conduct of the Board, health committees and staff, in relation to exhibiting a healthy lifestyle and a commitment to the goals of the organization. In practice, the elder played an influential role in the organization by providing practical advice to the Board and participating in their decision-making,

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<sup>69</sup> Cassidy Frank, Robert L. Bish, Indian Government: Its Meaning in Practice, Lantzville, British Columbia: Oolichan Books and the Institute on Public Policy, 1989, 86-89

attending all the Board meetings and while there was no reference to his voting rights in the organizational bylaws, the Board developed a customary practice of providing the elder with full voting rights at their meetings.

### **MSB Authority and Responsibilities**

The continuing responsibilities of MSB under the Agreement included a variety of functions. First, the ongoing capacity and availability of support to intervene in the PBCN communities in the event of epidemics, disasters and major community health emergencies to which Health Services Inc., was unable to respond to, refused to act and/or took ineffective action. This provision was to ensure the intervention of MSB to provide ongoing health services in the event PBCN Health was not meeting mandatory program requirements or having financial problems leading to a breakdown in community health programs.<sup>70</sup>

Second, MSB agreed to the monitoring and assessment of PBCN Health to ensure they were fulfilling the mandatory health program requirements and being financially accountable for the funding provisions under the Agreement.<sup>71</sup>

Third, MSB agreed to provide program support, consultation, research and advisory services to PBCN Health in the areas of nutrition, addictions, nursing, health education and dental prevention and education; as well as centralized research and planning services for relevant health data; and capital planning services for the construction and renovation of health facilities. With respect to nursing program support for example, the MSB had to provide PBCN Health with documents relating to standards used by the MSB nursing program including a community health manual

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<sup>70</sup> PBCN, et.al, The Health Transfer Agreement, *ibid.*, s. 8, s.42

<sup>71</sup> *ibid.*s.8

for nurses, the regional policy and procedure nursing guidelines, transfer of medical function, and clinical guidelines.

Fourth, MSB provided continuing provision and management of Non-Insured Health Benefits (NIHB)<sup>72</sup> to PBCN members including medical transportation, dental services, prescription drugs, prosthetics and orthotics, vision care and medical equipment. There was also a provision for the potential negotiation in the future for PBCN Health to take over the administration and control of NIHB services for its members.<sup>73</sup>

Fifth, MSB also provided PBCN Health with equal access to available MSB training programs such as basic professional training for community health representatives and NNADAP<sup>74</sup> prevention workers and clinical skills training for nurses. In regards to NNADAP, the MSB agreed to provide technical advice and support on addiction programming including research, training, treatment, prevention and other initiatives. They agreed to provide access to the certificate Chemical Dependency training. In broader issues, MSB agreed to assist PBCN Health in their implementation of health services. They also retained the ownership and responsibility for all fixed assets including the health center facilities and nurses' residences and others structure permanently located on land and associated fixtures to these buildings, but PBCN Health was provided funding to operate and manage the health facilities and nurses' residences.<sup>75</sup>

### **MSB Relations**

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<sup>72</sup> NIHB benefits are 3<sup>rd</sup> level services managed by MSB and not transferred to PBCN Health.

<sup>73</sup> PBCN, et.al., The Health Transfer Agreement, *ibid.*, s. 9(2)

<sup>74</sup> refers to the National Native Alcohol and Drug Addictions Program

<sup>75</sup> *ibid.*, s. 19, 20



The Board's relationship with the federal government through MSB was directly linked to the provisions in the Transfer Agreement dealing with the special relationship between the Crown and First Nations with respect to ensuring the health and safety of the First Nations. The regional (provincial) and zone (Prince Albert) offices of MSB were the primary government contacts for the organization with respect to operational issues and the provision of ongoing support, consultation, research and advisory services in various programs, centralized research and planning services, capital planning, and the continuing management of the Non-Insured Health Benefits program.<sup>76</sup> The Board and management staff of the organization had a positive working relationship with the MSB staff, in particular the zone director who was more involved than the other officials in the initial developments of the organization and had become familiar with the developmental processes of the Board.

### **Conclusion**

What the PB Health Transfer Agreement did was essentially provide a political and legal framework for the PB Health Board to manage and administer health services autonomously from Chief and Council. This was a departure from the traditional way of having the government funding flow through the Band administration system and essentially being governed by Chief and Council either directly or through some local advisory Board or committee. In the other programs under the Band administration, the Chief and Council, not the advisory committees, were normally held accountable for the management of the financial agreements, but with the PB Health Transfer, the Board was held accountable because of the authority

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<sup>76</sup> The PBCN Health Services Inc., clauses 8-10 of the PBCN Health Services Transfer Agreement, Prince Albert, Sask.: 1995, and also the PBCN Health Services Directional Plan, Prince Albert, Sask.: PBCN Health Services, 1995, 14

devolved to the corporation to manage and deliver health services on behalf of Chief and Council. The direct funding flow to the PB Health corporation, the Community Health Plan and the fact that Chief and Council members could not be Board of directors gave the Board and corporation an arms length authority to operate independently with the Chief and Council playing more of a political monitoring and advisory role through the Portfolio Councilors and designated elder(s). The role of MSB as a funding agency and policy authority likewise changed to a fiscal monitoring and consulting role in the PB Health operations.

## CHAPTER 6 IMPLEMENTATION – THE FIRST YEAR (1995-1996)

### Introduction

This chapter describes the setting up of the PBCN<sup>1</sup> Health Governance model and the experiences of the PBCN health Board of directors in the 1st year (1995-1996) of the five-year PBCN Health Transfer Agreement. The first year was a landmark year in the evolution of the PBCN health organization because it was a developmental year and the Board was under some political and administrative pressure to demonstrate that they could manage and deliver health programs and services effectively and according to the terms of the Agreement. There had been some concerns with the financial deficit situation of the Band and MSB wanted some certainty that all health funding would go towards community health programs and not “to any other Band program or for other Band operations.”<sup>2</sup> Consequently, through a series of Band council resolutions, the Chief and Council delegated the management, administration and financial control of all their health care services and programs to the PBCN Health organization.<sup>3</sup>

The Transfer process itself broadly consisted of pre-transfer, implementation and evaluation. Pre-transfer was discussed in the last chapter. The implementation component is being divided into 2 sections – the first year and the last four years. This chapter is about the first year. The following chapter will cover the remaining four years. The findings of the required evaluation survey are referenced throughout

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<sup>1</sup> Acronym for the Peter Ballantyne Cree Nation; also used in reference to the “Band” or “Chief and Council.”

<sup>2</sup> The PBCN Health Services Inc., clause 17 (1) of the “PBCN Health Services Transfer Agreement,” Prince Albert, Sask.: 1995, 12

<sup>3</sup> PBCN, Band Council Resolutions dated July 14, 1994, January 26, 1995, March 17, 1995, Prince Albert, Sask.



the discussions but are covered in better detail in the conclusion chapter. The only references to any type of evaluation of the first year experiences relate to the development of an evaluation plan and the general findings of a summer student survey done in the first year canvassing the opinions of community people, Chief and Council and health staff about their views on PB Health.

The implementation process consisted of a transition phase, 6 months prior to the actual takeover of health services and a post-transition phase, which was when the Board started delivering all health services to the PBCN communities. The transition phase required the Health Board to complete the community health plan, set up the organization, and take over the supervision of the existing MSB and Band health staff. The Board had a deadline to get all the preparatory work done by September 1995 at which time they would officially take over the management and delivery of all health services and programs to the PBCN communities identified in the Agreement. They continued to rely on the Transfer Negotiation team throughout this period and on a more permanent basis afterwards through various business arrangements, including the hiring of several of the team members, all of which helped provide support and continuity with respect to corporate knowledge and administrative expertise.

While the Board was involved in many things, some of their experiences were selected as examples to help explain the decision-making processes and practices of the Board, how they reached their decisions, what issues were raised, how different interests and priorities were balanced, how options were developed and chosen, how they accounted for their decisions and how they communicated these decisions to the

Chief and Council, the government and to their membership public.<sup>4</sup> These experiences illustrate the Board's dealings regarding the various governance aspects of power and authority, accountability, relationships and political culture. These are summarized here as a way of focusing the forthcoming discussions.

### **Power & Authority**

The governing power of the Board refers to the institutional and legitimate authority that flowed from corporate legislation and the contractual relationship they had with the federal government (MSB Health Canada) and the PBCN Chief and Council through the Health Transfer Agreement.<sup>5</sup> Under the non-profit legislation, the authority was vested in the Board as a whole and not as individuals; therefore, Board decisions were corporate decisions with the exception of those delegated to individuals from time to time. Essentially the power of the Board covered the entire management and direction of the organization, but administratively, their work was limited to policy functions and the making of larger organizational decisions. Board policy was to delegate administrative authority for day-to-day operations to the management and staff of the organization.

The Board philosophy in exercising their power and authority under the Agreement was to do so equitably, and in a diplomatic and caring fashion. Words like holistic, equality, cooperation, working together, and others are found in the foundational policy documents like the Community Health Plan and Directional Plan. Although the Board clearly had jurisdiction to govern the organization autonomously,

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<sup>4</sup> Plumptre Tim, John Graham, "Governance and Good Governance: International and Aboriginal Perspectives," Institute on Governance, December 3, 1999 – frame aboriginal governance around power, relationships and accountability: Who has influence, who decides and how decision-makers are held accountable.

<sup>5</sup> PBCN Health Transfer Agreement, clause 3, Prince Albert, Sask: 1995

politically and culturally, they were still influenced by the political authority of the Chief and Council. As a matter of political protocol, it was understood that Chief and Council would be the key negotiators with the federal governments in matters relating to the Health Transfer, such as renewals or amendments to the Transfer Agreement. Under the Corporate Bylaws, the Chief and Council retained the power to approve Board and health committee representatives, and approve changes to the Bylaws. This did not mean, however, that the Chief and Council could overrule Board decisions in the organization. As ex-officio representatives on the Board, the Chief and Council could participate in the Board meetings but could not vote.

The challenge for the Board was to find workable means and ways for balancing their administrative power and authority with the political power of the Chief and Council and at the same time, providing access for meaningful participation by the Chief and Council and other members of the community, such as health committees, in the policy and decision-making functions of the organization. The task was to find diplomatic and politically sensitive ways of providing access and inclusion for all the key players. The Board's approach for managing and balancing these relationships among the key players was to integrate their participation through standardized governance and operational policies and procedures. The organizational bylaws and operational manuals outlined the various roles and functions of the various key players. These organizational standards and rules also applied to the Board. For example, their accountability requirements included regular reporting to both the Chief and Council and the community. This structural inclusion provided opportunities for the Board and everyone else to negotiate their internal and external



working relationships and while conflicts were inevitable, as reflected in the Board experiences, there was a certain order and discipline in the policy processes which helped guide the people involved to find acceptable if not common ground.

### **Accountability**

The accountability of the Board was primarily to the PBCN membership through the Chief and Council as trustees of the PBCN membership, and the federal Minister of Health through MSB, as the primary funder and representative of the Crown. The dictionary definition of "accountability" is "to give a reckoning or explanation for one's actions,"<sup>6</sup> and its application with respect to First Nation governance has usually been through federal government service contracts outlining conditions with respect to fiscal management, public answerability, and program performance. The Auditor General Reports (1987, 1999, 2002), for example, directed both of the key federal departments dealing with First Nations, the Department of Indian Affairs and the First Nations Inuit Health Branch of Health Canada, to enforce stricter financial and program controls in their funding Agreements.<sup>7</sup> It has also been defined in relation to contemporary First Nations development as "the management practice that defines key reporting relationships and the chain of command within an organizational structure."<sup>8</sup> In relation to PBCN, the Board was obligated to comply with the mandatory program delivery and reporting requirements of the Transfer Agreement by following the guidelines outlined in the PBCN Community Health

<sup>6</sup> Hawkins Joyce M., The Oxford Large Print Dictionary, Toronto, Canada: Oxford University Press, 1989

<sup>7</sup> Minister of Public Works and Government Services Canada, Report of the Auditor General of Canada to the House of Commons, Chapter 10-Indian and Northern Affairs; Chapter 13 - Health Canada-First Nations Health, Ottawa: 1997; Follow-up April 1999; 2000. Website for Health Canada - <http://www.oag-bvg.gc.ca/domino/reports.nsf/html/0015ce.html>

<sup>8</sup> *ibid.*, page 25, quoting Anderson Robert B., Economic Development Among the Aboriginal Peoples in Canada: The Hope for the Future, Captus Press, 1998, 170

Care Plan for delivering mandatory programs such communicable disease control, treatment services, and community emergency response plans.<sup>9</sup>

The Chief and Council's purpose in forming the separate Board and corporate organization had been to accommodate the growing political pressure by the communities for a more accountable health delivery system which was arms length from the politics associated with the Chief and Council. The Board had a similar intention of establishing better administrative accountability through a more organized standard system of policies and procedures to guide organizational behavior. The belief was that standard principles and practices would help build a more neutral and equitable health system for everyone regardless of personal political influence or social standing.<sup>10</sup> The Board acknowledged that while the PBCN political culture had been rooted in traditional kinship and communal values of spirituality, sharing, equitable access, cooperation, respect and hospitality,<sup>11</sup> it had changed through the years of government dependency and Band politics to become more competitive and divisive along family and kinship lines especially when it came to Band elections and allocating Band resources.<sup>12</sup>

The potential for Board members and management staff to make biased decisions in favor of their families and friends over other band members, particularly with respect to employment, was a concern for the Board when they were first developing the various operating manuals for the organization and they addressed

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<sup>9</sup> The PBCN Health Services Inc., clause 7, Appendix 'F' of the "PBCN Health Services Transfer Agreement." Prince Albert, Sask.: 1995

<sup>10</sup> PBCN, The Community Health Care Plan, January 1995, PBCN, Pelican Narrows, Sask.: January 1995, 7 under "philosophy."

<sup>11</sup> See Chapter 3 of thesis, 5 to 8

<sup>12</sup> See Chapter 3, 32

these through various conflict of interest provisions, codes of ethics and structured hiring policies in the Personnel Manual.<sup>13</sup> The individual Board members, even if they disagreed or were affected by personal biases, were consistent in their practices to abide by decisions made by the majority of the Board. For example, there were cases when the Board helped resolve differences in how the different communities were interpreting various Board policies and procedures. For the first few months, there had been no consistency in the selection requirements and practices among interview committees with some requiring Board approval for their decisions and others not. The Board direction in resolving these differences was to find more efficient methods for selecting potential employee such as interview scoring charts for the interview committees to use, and changing policy requirements<sup>14</sup> delegating authority to the interview/selection committees to make the selection decisions on staffing positions, with the exception of management positions which still needed Board approval.<sup>15</sup>

The confidentiality processes required of the Board helped to develop a form of Board discipline where they could discuss things freely among themselves and reach a consensus, and even if some disagreed with the end result, the discussions were kept confidential to prevent them from being singled out and blamed for potentially politically sensitive decisions. Board Policy was to have their decisions

<sup>13</sup> PBCN Health Services Inc., "The Personnel Manual, 1995," Prince Albert, Sask.: 1995

<sup>14</sup> PBCN Health Services Inc., The Personnel Manual, PBCN Health Services Inc., Prince Albert, Sask.: 2000, under "recruitment and hiring," 11-12

<sup>15</sup> PBCN Health Services Inc., Board Minutes, October 1996, PBCN Health Services Inc., Prince Albert, Sask.: 1996; also in Executive Director Report, October 1996, *ibid.*



communicated to the general public through the Executive Director or in certain situations such as senior management terminations, by the Board chairperson.<sup>16</sup>

### Relations

The first key relations that the Board had under the Transfer Agreement were with the other two government signatories – MSB and the PBCN Chief and Council. MSB represented the interests of the Minister of Health and ultimately Parliament and the Chief and Council represented the interests of the PBCN Band members living in the four Health Transfer communities of Pelican Narrows, Deschambault Lake, Southend and Sturgeon Landing. The other key relations were the internal relations with the Health 'Administration' and the external relations with the 'Community' and 'Other' agencies.

One of the key themes in governance is relationship. Governance is generally about the study of any form of collective action and decision-making whether it involves private, public and civic organizations, sectors, regions, continental and global arrangements.<sup>17</sup> Most scholars agree that it has to do with strategic aspects of decision-making or 'steering' by organizations or societies apart from the more traditional notion of the state governing society.<sup>18</sup> Some suggest that governance is a complex socio-economic system involving much more than being a guiding or steering mechanism by the public sector or government. It is concerned with

<sup>16</sup> PBCN Health Services Inc., *The Administration Manual*, PBCN Health Services Inc., Prince Albert, Sask.: 2000, 84, under "media inquiries," also in *Board Minutes*, March 1996

<sup>17</sup> Paquet Gillies (organize), David M. Hayne (ed.), *Governance in the 21<sup>st</sup> Century: Transactions of the Royal Society of Canada, Series VI, Volume X*, 1999, Toronto: University of Toronto Press, 2000, 14

<sup>18</sup> Plumptre & John Graham, *Governance and Good Governance: International and Aboriginal Perspectives*, December 3, 1999, Ottawa: Institute on Governance, 1999, 3-5; also, Pierre Jon, (ed.), *Debating Governance: Authority, Steering and Democracy*, New York: Oxford University Press Inc., 2000, 242

coordination functions and the distribution of rights, obligations and powers.<sup>19</sup> Some caution that organizations cannot be viewed as closed technical systems because they are affected by their environment and vice versa.<sup>20</sup> All these, however, suggest an integrated approach where governing entities essentially steer or coordinate both internal and external relationships to achieve their goals, and in the process of policy-making and decision-making, they also influence as much as various interests influence them. In the PB situation, therefore, it will be helpful to consider the roles and interactions between the Board and the other key players in health in order to better understand the degree of influence all sides had in the making of policies and decisions.

### **Political Culture**

Political Culture is a political science term normally associated with "a particular patterned orientation toward political actions (which) tries to empirically describe and explain these patterns by measuring attitudes characteristic of a national population."<sup>21</sup> Political culture refers to the generalized political attitudes and values that people in a society have toward their political system, and it is usually determined by public opinion polls, although it can also be inferred through group or individual relationships with the political system.<sup>22</sup>

Political Culture was used here to help describe the political 'environment' that the Board had to work under such as the kinship relationships that pervaded

<sup>19</sup> Paquet Gillies (organize), David M. Hayne (ed.), *Governance in the 21<sup>st</sup> Century: Transactions of the Royal Society of Canada, Series VI, Volume X*, 1999, Toronto: University of Toronto Press, 2000, 14

<sup>20</sup> Mark Turner, David Hulme, *Governance, Administration and Development: Making the State Work*, West Hartford, Connecticut: Kumarian Press, 1997, 2

<sup>21</sup> Brodie Janine, Sandra Rein, eds., *Critical Concepts: An Introduction to Politics: Third Edition*, Toronto: Pearson Prentice Hall, 2005, 359, glossary

<sup>22</sup> Ball Alan R., *Modern Politics and Government*, 2<sup>nd</sup> Edition, Hong Kong: The MacMillan Press Limited, 1997, 21

much of community life and the strong influence of Chief and Council in community matters. Many scholars similarly include environment as an integral component in the study of governance because most interactions and business occur within political environments. Development scholars, Mark Turner and David Hulme, for example, suggest that political considerations need to be considered in analysis and practice in order to better understand the political landscape in which society, state and organizations interact. These essentially become the important "map" of power and authority.<sup>23</sup> Gilles Paquet suggests that governance is more than steering, it is the coordination of a complex socio-economic system characterized by deliberations and negotiations towards more common directions.<sup>24</sup> Scholars on Aboriginal governance also suggest that organizations have to fit their own particular settings or political culture environments in order to be sustainable.<sup>25</sup> There is an assumption that Aboriginal organizations will be different from other organizations in the larger society and even among different communities because of their differing cultural values and worldviews. It is anticipated that Aboriginal organizations will be more collectivist and holistic oriented, less hierarchical, with more consensus styles of decision-making and the inclusion of elders as advisors and teachers. While these assumptions may or may not be valid, what is important is that they acknowledge that

<sup>23</sup> Mark Turner, David Hulme, *Governance, Administration and Development: Making the State Work*, West Hartford, Connecticut: Kumarian Press, 1997, 2-3

<sup>24</sup> Paquet Gilles (organize), David M. Hayne (ed.), *Governance in the 21<sup>st</sup> Century: Transactions of the Royal Society of Canada, Series VI, Volume X, 1999*, Toronto: University of Toronto Press, 2000, 15-16

<sup>25</sup> Depew, Robert C., *First Nations Organizations: An Analytic Framework*, Ottawa: Indian and Northern Affairs Canada, Research & Analysis Directorate, July 1994, in his "forward" statement; also, Chapman Ian, Don McCaskill, David Newhouse, "Management in Contemporary Organizations" in *Canadian Journal of Native Studies*, 7 (2), 1991, 333



culture, in this case political culture, does influence the decisions made by decision-makers in Aboriginal communities.

The kind of health system that the PBCN communities desired suggests a certain political culture wanting change from a health system dominated by government authorities to one of local control. PBCN envisioned a health system that went beyond the focus on institutionalized medical treatment to one that was more holistic and had other mental and social community-based support programs and services for people to access towards better health. The community health plan described this holistic approach to health as "a general state of total well-being and effective functioning rather than just an absence of physical illness."<sup>26</sup> While it is unclear how much and what way PBCN cultural history might have had an influence, there is sufficient evidence to suggest that their traditional culture, particularly the importance of family relationships and the communal nature of their way of life, did have an influence in what they wanted their health system to do and how they wanted it to act. In that sense, the challenge for the Board was to come with tangible and visible results of sound management and new programs to the communities particularly in the first year when public scrutiny was particularly strong.

#### **Mission & Guiding Values**

The PBCN Community Health Care Plan was a requirement of the transfer negotiations and served as the primary guiding document for the organization and the basis for the strategic policy direction that was later developed by the Board in the PBCN Health Directional Plan. The Community Health Plan described the

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<sup>26</sup> PBCN, PBCN Community Health Care Plan, January 1995, PBCN Health Services Inc., Prince Albert, Sask.: 1995, 9

philosophy and goal of Transfer and a description of the required health services and programs that PBCN Health was to deliver to the four Transfer communities. The primary goal reiterated throughout the planning documents was to build a sustainable community-based health system in each of the communities based on values of "balance, of wholeness, of optimum well-being and of the realization of all of one's potentialities."<sup>27</sup>

The guiding principles or values of the organization were to ensure that Indian people must have equal access to health services of the same range and quality as is available to the rest of the province; that PBCN Health Services must incorporate the holistic approach to meet the individual, family and communities' spiritual, cultural and social needs; that cooperation with other health delivery systems shall be ongoing on an equitable basis for the benefit of all; and that it is the right of Indian people to determine their own needs and to design and control a health delivery system to meet their needs."<sup>28</sup>

The mission statement reflected the purpose of the Transfer and helped guide the PBCN Health Board in their governing work. The mission statement was to "provide and facilitate a holistic health service that promoted physical, mental, emotional and spiritual wellness to its members in the communities of Pelican Narrows, Deschambault Lake, Southend and Sturgeon Landing."<sup>29</sup> The mission statement was prefaced in all the key PBCN Health planning and policy documents as the guiding purpose and framework.

### **Corporate Duties and Responsibilities**

<sup>27</sup> PBCN, *The PBCN Community Health Care Plan*, Pelican Narrows, Sask.: January 1995, 7

<sup>28</sup> PBCN Health Services Inc., *Directional Plan*, Prince Albert, Sask.: PBCN Health Services Inc., 7

<sup>29</sup> PBCN Health Services Inc., *Directional Plan*, Prince Albert, Sask.: PBCN Health Services Inc., 4

The duties and responsibilities of the PBCN Health Services under the Agreement were to deliver, administer, provide and control health services through the guiding objectives and activities described in the PBCN Community Health Care Plan.<sup>30</sup> The Board, on behalf of the organization, was held liable for any potential medical malpractice and professional liability resulting from the Agreement and was responsible for ensuring that the organization had proper insurance coverage. The financial accountability of PBCN Health was only for funding health programs and services. It could transfer program funds to other health programs and services as long as the mandatory program requirements were met. It was clear, however, that PBCN Health could not transfer program funds to any other Band administered programs or for other Band operations.<sup>31</sup> Any surplus funds at the end of the year could be used to fund other health-related programs and services and supplies; on the other hand, PBCN Health was also responsible for any operating deficits and ensuring that all the financial and program accountability requirements of the PBCN Health organization were being met. This included maintaining the privacy of medical information and other confidentiality requirements of the Agreement.

The parties also agreed to set up a service implementation and monitoring committee for the first year of the Agreement for the purposes of reviewing the annual report, population issues, capital issues and other related health service issues, but in actual practice, the committee was kept informal with meetings called as needed.

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<sup>30</sup> PBCN, PBCN Health Services Inc., Minister of National Health and Welfare Canada, The PBCN Health Transfer Agreement, 1995, PBCN Health Services Inc.: Prince Albert, Sask.: March 17, 1995, s.4(1)

<sup>31</sup> *ibid.*, s.17



The health programs that PBCN Health was required to implement under the Agreement included community health services, community alcohol and drug abuse services, health education, capital assets, management & administration, management of community health center facilities, nursing services, mandatory programs, pharmacy contract services, and having an evaluation study in the final year.<sup>32</sup>

## IMPLEMENTATION

The official work and activities of the Health Board began in phase 3 - the implementation of the Transfer Agreement. However, before they actually took over the complete administration and transfer of health programs, there was about a 6-month transition period<sup>33</sup> between the inaugural meetings of the new Board on March 16<sup>th</sup>, 1995, the signing of the Transfer Agreement the next day on March 17<sup>th</sup>, 1995 and September 1<sup>st</sup>, 1995.<sup>34</sup> This transition period was essentially to prepare the Board and organization for the September takeover.

During this preparatory phase, the task was to set up a workable organizational structure, hire key management and program delivery staff, provide for staff training and orientation, develop the various administrative and program development policies and plans required by MSB, attend information sessions at community meetings, organize and train local health advisory committees, assume supervision over existing health staff in the various community health centers, hire new staff and provide a staff

<sup>32</sup> PBCN, *The PBCN Health Transfer Agreement*, *ibid*, s.4

<sup>33</sup> PBCN Health Services Inc., Pamphlet entitled, *Peter Ballantyne Cree Nation Health Services Transfer: Working Together Towards Healthy Families and Communities*, Prince Albert, Sask.: 1995

<sup>34</sup> Refers to the Medical Services Branch of Health Canada, the federal department responsible for coordinating the Health Transfers of all Bands across the country.

orientation conference to update everyone on the PBCN health organization.<sup>35</sup>

These included all community nurses, community health workers and holistic health workers<sup>36</sup>, clerical and other support staff, health committees, Board, the Chief and Portfolio Councilors.<sup>37</sup>

While the new management staff in Prince Albert did most of the organizing work, they were advised and supported by the pre-transfer negotiation team. The PBCN negotiation team had been appointed by the Board as an interim management team for the Board during the transition period, and they continued providing much of the necessary technical and administrative support after the new management staff were hired. The combined political, administrative, legal expertise and experiences of the individuals involved in the interim management team were critical in the 6 month period leading up to the Board's actual takeover of medical services in September 1995. The Chief and health Portfolio Councilors involved in the management team had extensive negotiating experiences with the federal government and were strong advocates for the Health Board that helped facilitate their political legitimacy and credibility. The management consultants and legal counsel had blended administrative and legal expertise and experience in the health field which enabled them to generally function as executive staff to the Board during the interim period.<sup>38</sup>

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<sup>35</sup> PBCN, "Band Council Resolution, August 3, 1994," Prince Albert, Sask.: 1994 provided a description of the phases of the health transfer process. Phase 1 and 2 were negotiations and program development.

<sup>36</sup> Originally called NNADAP workers - alcohol & addiction councilors; now under PBCN, they were called holistic health workers to indicate broader mandates not just alcohol and drugs

<sup>37</sup> PBCN Health Services Inc., Board minutes, July 1995, Prince Albert, Sask.: PBCN Health Services Inc., 1995

<sup>38</sup> PBCN Health Services Inc., Board Minutes, March 16, 1995, Prince Albert, Sask.: PBCN Health Services Inc., 1995

The Board had a steep learning curve balancing on the one hand, the necessity of gaining working knowledge of their legal responsibilities under the Transfer Agreement and on the other hand, learning what a Board was supposed to do when running a corporation, particularly when that corporation was supposed to be delivering health programs right away. Fortunately, in addition to the expertise of the PBCN negotiation team, the pre-existing program infrastructure left by MSB<sup>39</sup> in the health centers and the policy groundwork that had been done by the Prince Albert Tribal Council<sup>40</sup> in their health transfer helped the Board manage the transition.

### **The Corporate Structure**

The corporate structure for the Board was based upon the administrative and legal requirements of the provincial Non-Profit Corporations Act which authorized the Board to be "the directing mind and control of the corporation," to oversee the management of the business and affairs of the corporation and to ensure that the staff were carrying out their directions in a way that achieved the corporation's objectives and obligations.<sup>41</sup> Ultimately, the Board was responsible for the performance of all the requirements in the PBCN Health Service Transfer Agreement "in respect of the delivery, administration, provision and control of health services."<sup>42</sup> In carrying out their duties, the Board were governed by the bylaws of the organization which required them to only approve health-related expenditures, they could not transfer program-specific funds to cover potential deficits, they had to maintain

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<sup>39</sup> Medical Services Branch, Health Canada – MSB provided previous health programming

<sup>40</sup> PATC is now PAGC, Prince Albert Grand Council

<sup>41</sup> PBCN Health Services Inc., "Board of Directors Orientation: September 13, 2000," handout, Prince Albert, Sask.: 2000;

<sup>42</sup> The PBCN Health Services Inc., clause 3 of the PBCN Health Services Transfer Agreement, Prince Albert, Sask.: 1995



confidentiality of all non-public matters relating to the organization, and they had to conduct their business in a professional and ethical manner.<sup>43</sup> As stewards representing the best interests of the PBCN membership, they were bound by a standard of care required of reasonable persons in similar situations and only the majority Board had the authority to recommend removal of Board members in cases of misconduct and only after following due process. This situation never arose to test the provision.

### **Decision-making**

Under the non-profit legislation and Bylaws of the organization approved by the Chief and Council, the Board was provided with a system for making decisions which generally limited their functions to policy making and approving the operational work plans and budgets and dealing with larger organizational issues, thus leaving the day-to-day operational decisions to the management and staff. The Board - administration relations were to be directed primarily through formal lines of authority and reporting as outlined in the PBCN Health organizational chart.<sup>44</sup> The roles and responsibilities were described in the Personnel and Administration manuals, with changes to these policies accommodated through annual management reviews and Board approval.<sup>45</sup>

The Personnel manual set out the employee-employer relationships between the Board and health staff and it was intended to guide organizational behavior

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<sup>43</sup> PBCN Health Services Inc., PBCN Health Services Incorporated Bylaws, Prince Albert, Sask.: 1995, 2

<sup>44</sup> see attachment

<sup>45</sup> PBCN Health Services Inc., Health Administration Manual, Sept. 1995; Revised February 25, 2000, PBCN Health Services Inc., Prince Albert, Sask.: 2000, 1 of *General Procedures*

through a systems of "standardized policies and procedures."<sup>46</sup> The mission was to design fair and equitable policies and procedures for all employees; provide a harmonious and efficient relationship with the employees; provide for an impartial and honest way for resolving differences with employees; to provide for their morale, well-being and security; and to provide for staff development and training opportunities.<sup>47</sup> It contained within it a code of ethics, an oath of confidentiality, a description of the management team responsible for the overall administration of the personnel procedures, and many provisions relating to the management of human resources.<sup>48</sup> The Board wanted to develop an organizational culture that was both competent and responsive to the overall mission and purpose of the organization. Their aim was to recruit and hire management and staff who were professionally qualified, committed to community development, and demonstrated healthy lifestyles.<sup>49</sup>

All employees were expected to sign an oath of confidentiality to protect patient privacy and to abide by the "code of ethics" which emphasized community service and the promotion and protection of First Nation inherent and Treaty rights and self-government.<sup>50</sup> The scope of the code of ethics was broad without a clear demarcation between the public and private lives of the employees and was essentially a list of prescribed behaviors which included: carrying out the conditions

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<sup>46</sup> PBCN Health Services Inc., The Personnel Manual, 1995, Revised Feb 25, 2000, Prince Albert, Sask., 2000

<sup>47</sup> *ibid*, 4

<sup>48</sup> PBCN Health Services Inc., The Personnel Manual, 1995; Revised Feb.25, 2000, Prince Albert, Sask.: 2000

<sup>49</sup> PBCN Health Services Inc., Directional Plan, Prince Albert, Sask.: PBCN Health Services Inc., 1995, 15 – 19, under sections describing roles of health staff.

<sup>50</sup> PBCN Health Services Inc., The Personnel Manual, 1995; Revised Feb.25, 2000, Prince Albert, Sask.: 2000, 5

of employment honestly, conscientiously and loyally, exhibiting positive public behavior, promptness, courtesy, treating people with respect, confidentiality, no public criticizing of the organization, staff and authorities, cooperating with supervision, not engaging in political activities which could be interpreted as "conflict of interest," and the promotion and protection of the PBCN traditional culture, language, values and history.<sup>51</sup> The Executive Director was ultimately responsible for interpreting and enforcing these terms with the employees, and it was understood that any violations could be subject to discipline by the Executive Director<sup>52</sup> and/or termination by the Board.<sup>53</sup>

The Board and management staff faced various challenges in implementing the organization policies with issues ranging from having to work with unclear operational procedures to managing the often-competing cultural differences between formal and informal employer-employee relations. Many of the community health staff, in particular, had difficulties in separating their personal and work lives and adhering to formalized organizational rules and work ethics. Most had grown up in community cultures where it was expected that people looked out for their families and relatives and that one did not have to behave differently towards others just because they were employed in a local job. Many had personal problems and family responsibilities which affected their work such as not showing for work or being chronically late,<sup>54</sup> some were used to having flexible time schedules to allow them to

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<sup>51</sup> *ibid*, 5-6

<sup>52</sup> PBCN Health Services, *The Personnel Manual 2000*, PBCN Health Services Inc., Prince Albert, Sask.: 2000, 37 under "disciplinary action."

<sup>53</sup> *Ibid*, 39 under "termination for cause."

<sup>54</sup> PBCN Health Services Inc., *Director of Community Development Report, September 1995, December 1995*.



go trapping and fishing, and others had difficulty with supervision, especially from other local staff. In one situation for example, the health coordinator reported problems in enforcing procedures such as staff taking extended coffee breaks or leaving without proper notification to their supervisors,<sup>55</sup> and in another, a staff complaint taken to the Chief and Council was brought before the Board protesting an alleged firing, but there had been a letter of resignation given, and in that case, the Board asked the health coordinator to meet with the staff member and get the matter clarified.<sup>56</sup>

The business structure and procedures adopted by the Board in conducting their meetings and making decisions were patterned after the generally accepted rules of order expected of corporate organizations,<sup>57</sup> and in accordance with the organizational Bylaws. Board decisions could only be made at properly constituted meetings and required a quorum of six directors and a majority vote to pass Board motions on significant matters. All approved motions were formally recorded and kept in binders as permanent records of the board's decisions. While Board members and portfolio councilors could amend the agenda and add their own issues, the general practice at most Board meetings was for the management team and later the Executive Director and/or Assistant Executive Director to present the agenda and provide reports and recommendations for Board consideration. This was slightly modified after the formal transfer in September when the Board requested that all program managers present their own reports to the Board.<sup>58</sup> The Board wanted to

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<sup>55</sup> PBCN Health Services Inc., Director of Community Development Report, September 1995

<sup>56</sup> PBCN Health Services Inc., Board Minutes, October 1995

<sup>57</sup> Robert's Rules of Order (USA); Bournot's Rules of Order (Canada, 1995 revised)

<sup>58</sup> PBCN Health Services Inc., Board Minutes, September 1995

dialogue with the various managers with respect to their programs. The elder participated in the Board process by providing opening and closing prayers and remarks at all the meetings.

In modern corporations, a board is considered as the heart of the governance of the organization, and while it has many duties and responsibilities to the organization, board governance is primarily involved in managing relationships with the various stakeholders, in particular the members affected by their operations,<sup>59</sup> rather than daily operations. In the case of PBCN, however, the first year was particularly busy for the Board and was more hands-on in the daily operations of the organization than was generally intended or expected. The Board had several main concerns: First, they had to ensure that the organization was legally operated, provided efficient health services and programs and administered the finances properly. Second, they had to develop ways to fulfill their political accountability to the Chief and Council and the PBCN membership by integrating formal participatory mechanisms into their decision-making through the representation of the Chief and Portfolio Councilors at Board meetings and by the legal requirement to publicly present the yearly program and audited financial reports of the organization at an annual meeting.

Another method of local participation was to keep and develop the community health committees that had been put in place by MSB prior to the Transfer. Although health committees were mentioned in the PBCN community health plan, they were

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<sup>59</sup> Gillies James, Boardroom Renaissance: Power, Morality and Performance in the Modern Corporation, Toronto: McGraw-Hill Ryerson Limited, 1992, 39; Also Wood, Miriam M. (ed.), Non Profit Boards and Leadership: Cases on Governance, Change and Board-Staff Dynamics, San Francisco: Jossey-Bass Publishers, 1996, 3

not required in the Transfer Agreement because of the community-representative nature of the new Board. However, the Chief and Council and Board believed that the local health committees would be an important means of providing local and public accountability for the organization, and therefore needed to be integrated into the Board decision-making process in an advisory capacity.<sup>60</sup> The intention was to have health committees meet regularly on local health issues and submit their recommendations to the Board on matters pertaining to the health programs and services in their communities.

### **Inaugural Meeting**

The inaugural meeting of the Board on March 16, 1995,<sup>61</sup> is worth noting because it set a pattern for the way the Board conducted their business throughout the ensuing years. The Board had representatives from the 10 PBCN communities although only 4 were covered under the Agreement, and at its inception, consisted of all women - 2 from Southend Reindeer lake, 2 Deschambault Lake, 2 Pelican Narrows, 1 Sturgeon Landing, 1 Prince Albert, 1 Denare Beach and 1 from Sandy Bay.<sup>62</sup> At the time, the Board was presented with a wide range of issues on the agenda from governance and community concerns to administrative necessities. These included:

“Nominations for the Health Chairperson and Vice-Chairperson, Health Board Bylaws, Health Transfer Agreement, Insurance Coverage, Banking Institution, Appointing of Solicitor, Signing Authority, Staffing Appointments, Advertising

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<sup>60</sup> PBCN Health Services Inc., PBCN Health Services Inc., 1995-1996 Annual Report, PBCN Health Services Inc., Prince Albert, Sask: 1995-1996, 4 “Chief’s Message,” and 9, “Executive Director’s Message.”

<sup>61</sup> PBCN Health Services, PBCN Board Minutes, March 16, 1995, Prince Albert, Sask.: 1995

<sup>62</sup> PBCN Health Services Inc., Bylaws, Prince Albert, Sask.: 1995, 1



Positions, Elder Appointment, Employee Benefits Broker, Interim Management, Assistant Executive Director Appointment and Physician and Dental Contracts.<sup>63</sup>

The chairperson was nominated and selected by acclamation. There were 2 nominations for vice-chair, but one declined and the other appointed also by acclamation. The Executive Director was appointed as secretary to the Board. The interim management team discussed the roles and responsibilities of the various executive positions, in particular, the significance of the chairperson who had the authority to call regular and special board meetings and to preside at these meetings, or in their absence, to delegate the vice-chair or other Board appointed person to do likewise. The chair's function was to manage the work of the Board and in between meetings, represent the organization's general interests as delegated by the Board and as required from time to time with respect to signing formal documents, presiding over internal committees, dealing with special operational issues, maintaining management accountability, speaking at public functions and attending community and other business meetings with political representatives and government officials.

There were no formal written guidelines for the Board to follow in selecting the type of persons needed for their chair and vice-chair positions. That in this case did not appear to be a problem since both individuals selected obviously had Board confidence in their leadership skills by keeping their executive positions for the duration of their terms.<sup>64</sup> The lack of guidelines was not unique to PBCN, in fact much of the literature on effective organizations stresses the importance of having effective chairpersons, but provides only generalized references to personal

<sup>63</sup> PBCN Health Services Inc., Board Minutes, March 16, 1995, Prince Albert, Sask.: 1995

<sup>64</sup> PBCN Health Services Inc., Annual Reports, 1995-96; 1996-97, Prince Albert, Sask: PBCN Health Services Inc.

leadership values and knowledge of meeting procedures.<sup>65</sup> In determining their selection, the Board made their decisions based on the information provided by the nominators who described the personal knowledge base and experiences of their candidates. Among other things, these had to do with advocacy and communication skills in both Cree and English, community involvement in committees and boards, familiarity with meeting procedures, and a strong interest in health issues.

The rest of the meeting was conducted in both Cree and English and dealt with

mostly non-contentious operational issues. The Board passed motions approving the organization Bylaws recommended by the Chief and Council, the Health Transfer Agreement scheduled for signing the following day, and the appointment of the

Transfer

negotiation team as interim managers until permanent managers were hired. An

insurance

company was chosen from a range of options presented by the management team to provide general insurance coverage for the organization and similar direction was given to the team to canvass proposals for the Employee Benefits Group Insurance requirements. Interim signing authorities were also approved to include one Board member and two members of the interim management team with a further directive limiting their authorization of expenditures to those deemed necessary for the effective continuation of the transfer process. A motion was made approving the

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<sup>65</sup> Gillies James, Boardroom Renaissance: Power, Morality and Performance in the Modern Corporation, Toronto: McGraw-Hill Ryerson Limited, 1992, 64-65; and Government of Yukon, "Boards and Committees Orientation Guide", Yukon: Yukon Public Service Commission, Staff Development Branch, 23

solicitor for the organization. The Board retained the services of the Band's legal counsel because of their expertise and experience with the Band and because they had also already been involved with the health transfer negotiations and had helped to set up the new health governance structure and were familiar to the Board members. Approval was also given to the management team to sign the physician, dentist and other necessary professional contracts on behalf of the Board.

With respect to elders' involvement in the organization, the Board approved the Chief and Council's appointment of an elder for the organization and added the provision that other community elders be invited to Board meetings whenever they were held in the communities. This addition followed a discussion about including community-based elders to assist the Board and organization in dealing with the health issues in their respective communities. The inclusion of elders was also a common protocol used by the Chief and Council at their Band meetings, and the Board followed that practice.

While most of the agenda issues were non-contentious, there were some that were politically sensitive such as those involving decisions around banking and staffing positions. The Board had generally been expected by the PBCN administration to choose the same bank, but they decided to opt for a different bank. At the time, the Board had to weigh the benefits and costs associated with following Band practice and going with a bank that was familiar with the Band or going their own direction and choosing a bank that may not have had experience with the Band and would have a steeper learning curve in dealing with the new Board. The Board



decided to choose a separate Bank because they felt that it would prevent confusion between Band and Health accounts and that it would keep the health funding safer from potential actions against the Band accounts by the federal government and other creditors, which was a good possibility at the time with the Band experiencing financial problems.

The Board also had to deal with concerns expressed by some Band members and Portfolio Councilors regarding their initial hiring processes for health managers. While the formal Board motions approving the hiring of key management staff took place at the inaugural meeting, the Board and Portfolio Councilors, with the support of the Chief, had previously interviewed and recommended the hiring of new senior management staff on short notice and were criticized by some for not having proper job postings and allegedly hiring based on political preference rather than merit.

While the Board expressed understanding of these concerns, they felt that it had been necessary to hire the initial managers quickly in order to expedite the work that had to be done during the transition period before the full transfer of health services from MSB scheduled for September. As well the interim management team, who were not employees, had advised the Board to hire permanent management staff to deal with the day-to-day operations of the organization. Following the hiring of the initial management staff, the Board then moved to develop more extensive and formalized hiring policies and procedures for the other management and staff positions both at the central Prince Albert office and the four community-based health clinics.<sup>66</sup>

## **6 Month Transition – Situations & Issues**

### Management capacity

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<sup>66</sup> PBCN Health Services Inc., Board Meeting, April 1995

In building the management capacity in the organization, the Board had chosen to apply a hiring approach for their management staff which required evidence of not only technical qualifications, but also a sensitivity and responsiveness to the particular needs and cultures of the communities served.<sup>67</sup> Finding the right people with the appropriate blend of technical and socio-political knowledge of PBCN was difficult and the Board experienced frequent management turnovers at the central office in Prince Albert during their first 6 months of operation.<sup>68</sup> The responsibilities and political pressures associated with the Executive Director position, in particular, made it challenging to keep the position filled and it took several attempts before the position stabilized.<sup>69</sup> While the Board were criticized for appearing to be exclusive and too business-like in their approach by those who felt that the high technical requirements were preventing aboriginal Band members from accessing the management positions, the Board strongly believed that the priority particularly in the developmental phase was to establish a technical capacity to develop the organization, and if qualified band members could not be found, then others would be hired.<sup>70</sup>

This approach by the Board to move towards a more objective form of hiring is consistent with what appears to be a growing trend in other First Nation communities. According to public administration literature on aboriginal self-government, more First Nations are starting to separate the political and

<sup>67</sup> Franks, C.E.S. Public Administration Questions Relating to Aboriginal Self-Government, Kingston, Ontario: Institute of Intergovernmental Relations, 1987, 59; also,

<sup>68</sup> PBCN Health Services Inc., PBCN Health Transfer Evaluation, August 1996, " Prince Albert, Sask.: PBCN Health Services Inc., 1996, 11

<sup>69</sup> PBCN Health Services Inc., PBCN Health Services Inc., Annual Report, 1995-1996, Prince Albert, Sask.: PBCN Health Services Inc., 7

<sup>70</sup> PBCN Health Services Inc., The Personnel Manual, 1995, Prince Albert, Sask.: 1995, 11

administrative spheres of Band government and negotiating acceptable balances of power between the elected officials and their civil service. This is resulting in some changes to hiring practices based less on personal and political relationships and more on showing evidence of technical expertise and community knowledge.<sup>71</sup> There is, of course, an alternative view that suggests that most hiring practices are still politically based upon family and kinship connections, and less on technical merit, thus perpetuating a class of Indian ruling elites on reserves, and rather than empowering the people, it empowers a class of "elected officials and appointed bureaucrats," who cannot be held accountable for their decisions.<sup>72</sup> While this fear of lack of accountability and too much power in the hands of a few was evident in some of the community surveys leading to transfer, and in the concerns expressed by some of the Band Councilors who were fearful of potentially losing control and guidance from the political leadership to a community Board, the Board was criticized more for having too many checks and balances in their administration, particularly in their financial controls, rather than lack of accountability. A 1996 summer survey described a general consensus among staff that PBCN Health was becoming too much like a business, worrying more about money rather than service.<sup>73</sup>

<sup>71</sup> Franks, C.E.S., Public Administration Questions Relating to Aboriginal Self-Government, Kingston, Ontario: Institute of Intergovernmental Relations, 1987, 59; also, Cornell, Stephen, Joseph P. Kalt, Reloading the Dice: Improving The Chances For Economic Development on American Indian Reservations, Harvard Project on American Indian Development, John F. Kennedy School of Government, Harvard University, March 1992; and Wayne Warry, Unfinished Dreams: Community Healing and The Reality of Aboriginal Self-Government, Toronto: University of Toronto Press Inc., 1998

<sup>72</sup> Boldt Menno, Surviving as Indians: The Challenge of Self-Government, Toronto: University of Toronto Press Incorporated, 1993, 130-131

<sup>73</sup> PBCN Health Services Inc., PBCN Person To Person Summer Survey, August 1996, Prince Albert, Sask.: PBCN Health Services Inc., 11, described the consensus among staff that Health Services



### Staff Transfers

The Board had to face many transition issues both internal and external to the organization. One of the internal issues involved some resistance from previous MSB and Band health staff who were part of a long historically entrenched culture of medical service delivery in the north where the staff were used to taking direction and being accountable to MSB officials rather than a community Board. There were also the external high expectations from many community members who were expecting to receive more personalized and responsive services from their own organization than they received from MSB.<sup>74</sup> Both probably could be attributed to the high political nature and profile of the pre-transfer process where door-to-door needs assessment surveys had been conducted resulting in the majority of the people wanting a transfer so that they could have more influence over the health services being provided to them, and where former health staff hired by MSB and the Band were expressing concerns with respect to job security, continuity of services and the general capacity of the new Board and management to properly govern health services.

The transfer of MSB nurses to the new health organization was particularly challenging because the Health Transfer caused a significant shift in the power relations between the nurses and community people. Under MSB, the historical practice was to have a nurse-in-charge administering the local clinic with other nursing staff providing the treatment and health programs supported by community health representatives. The shift in administration to a community health coordinator and the hiring of other community staff to work with the nurses in the various health

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<sup>74</sup>PBCN Health Services Inc., Board Minutes, April, June 1995

programs moved much of the focus away from a nursing to a broader community orientation.<sup>75</sup> While this shift did alleviate some of the dependency upon nurses in the administration of the clinic and delivery of programs, the nurses still provided the primary medical treatment services for the communities and thus continued to have a strong influence with the organization. The expanded scope coverage by MSB for northern nurses allowed them a greater autonomy than nurses in the south to diagnose and treat patients in the clinics, even though they were still under the direction of physicians who were under contract with the organization.<sup>76</sup> As well, the high demand and low supply of nurses in general by the medical system across the country made it more difficult for the Board to keep and recruit nurses in their communities, and it provided the nurses with strong bargaining powers in terms of their salaries and conditions of employment with the organization.

Most of the pre-transfer nurses resigned during the transition process due to uncertainties related to the management transition from MSB to a Band health organization as well as the ongoing heavy workloads in the communities. The Board was faced with balancing several priorities, the need for staffing the nursing positions in the communities and for implementing their own management systems and policies at the risk of losing more nursing staff. The immediate problems were resolved by getting relief nurses into the communities through contracts with the Nightingale group, which is an organization that contracts and provides relief nursing to the

<sup>75</sup> Young T. Kue, *Health Care and Cultural Change: The Indian Experience in the Central Subarctic*, Toronto: University of Toronto Press, 1988. 87, indicated that the first nursing station – residence-clinic for a nurse on reserve – was opened in 1930 at Fisher River, Manitoba.

<sup>76</sup> PBCN Health Services Inc., *Nursing Manual*, Sept 1, 1995, revised February 25, 2000, PBCN Health Services Inc., Prince Albert, Sask.: 2000, 65 under “nursing treatment service to the community.”

northern regions, and through aggressive recruiting efforts by the nursing director through advertising, word of mouth, and referrals from other nurses and health agencies. The recruitment and retention of qualified nurses, however, continued to be a challenge for the organization in the first year and even the final year of the Agreement. Nursing Service Reports regularly mentioned frequent staff turnovers and attributed them to heavy workloads and other job offers.<sup>77</sup>

#### Program Transfers

Many of the contribution agreements (year to year funding) that health took over in March also had to be reimbursed to the Band administration (1/12 of the total) for the period leading up to Sept 1, 1995, when the health organization assumed all program funding control.<sup>78</sup> One of the programs under Transfer that had previously been administered by the Band was the "Building Healthy Communities/Brighter Futures Program." The Brighter Futures initiative was set up in 1992 by Health Canada to improve the quality of services to communities and families. The initiatives included the mental health program, parenting skills, child development, healthy babies program, solvent abuse program and injury prevention.<sup>79</sup> The Band program managers had expressed concerns with the transfer of the administration of this program to the new health organization and had wanted to keep the program under Band administration. The concerns had to do with who was going to run the program, whether the health organization had sufficient capacity to do so, salary structures, and the ongoing support for the program staff in the other

<sup>77</sup> PBCN Health Services Inc., Director Nursing Services Report November 1995

<sup>78</sup> PBCN Health Services Inc., Board minutes, April 1995

<sup>79</sup> PBCN Health Services Inc., Background Information: Brighter Futures Plan, October 1995, PBCN Health Services Inc., Prince Albert, Sask.: 1995



communities.<sup>80</sup> The Board addressed this program transition by inviting the Band program managers to discuss their concerns at several Board meeting and meetings with the health managers. Assurances were given by the Board chair that the Board would work together with them to solve some of their concerns. After several months, these Band administered programs were completely transferred to PB Health along with most of the former staff employed under them.

#### Policy-Making - Administration and Personnel Manuals

According to the organizational chart, the Board was held ultimately responsible to the community people for the way the organization delivered services to them. The general practice in the communities had been for individuals to take their concerns directly to the Chief and Council, and with the creation of the Board, that practice was changed with respect to health issues and the Chief and Council were now advising people to take their concerns to the local health managers and the Board for resolution. This resulted in some confusion and frustration with respect to the political authority and relationship between the Chief and Council and the Board.<sup>81</sup> Furthermore, the Board in attempting to keep away from intervening with the daily operations of the organization would direct community people to the local managers, thus appearing to subordinate the authority of the Board to the local health managers and staff. Therefore until people were more familiar with the administration processes of the organization, the Board members were often called upon to resolve matters.

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<sup>80</sup> PBCN Health Services Inc., Board Minutes, June 1995

<sup>81</sup> PBCN Health Services Inc., Board Minutes - April, 1995, Prince Albert, Sask: 1995

The Executive Director and management team from the Prince Albert central office were held responsible for the management and supervision of all the health centers delivering programs and services in the communities. In dealing with personnel issues, in particular, Board familiarity and knowledge of the community people and culture were particularly valuable for those managers who were new to the communities and the people. The Board members frequently traveled to the communities to attend informational meetings and orientation workshops and often provided guidance to the PA staff in dealing with the supervision and discipline of community staff for such things as not showing up for work, alleged confidentiality breaches of private information, and concerns with insubordination.<sup>82</sup> In dealing with these issues, it became evident to the Board very early in the process that in order to provide clearer direction and to streamline the work of the Board and the staff of the organization, they needed to develop uniform governing policies in order to build the capacity of the organization and to create an organizational culture that was both competent and responsive to the overall mission and purpose of the organization. Policy-making was a way of bringing some order to a complicated delivery system spanning many communities, although it has also been generally recognized as being an integral component of effective board governance.<sup>83</sup>

The major organization policies included the Community Health Plan, The Directional Plan, the Administration and Personnel Policy Manual and the various Program Manuals such as nursing, community development and home care. These manuals were developed and approved by the Board in the first 6 months of their

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<sup>82</sup> PBCN Health Services Inc., Board Minutes – April, July, August, 1995, Prince Albert, Sask: 1995

<sup>83</sup> Deloitte & Touche, The Effective Not-For-Profit Board: Governance of Not-For-Profit Organizations, Canada: Deloitte & Touche, 1995, 18

operation and were later presented at a three-day staff orientation and training conference for all the community health staff, health committees, community elders and Chief and Council. The processes involved in developing these manuals emphasized community participation. The Board felt that uniform operational standards and health programs and the identification of common goals among the communities would address the desired values and community vision identified in the community health plan with respect to ensuring "equal access" and "equity" in the delivery of health services.<sup>84</sup>

This formalization of operational and program policy-making obligated the Board to engage in extensive long-term planning exercises with their various stakeholders. The drafting of the Directional Plan, in particular, was important for establishing a foundation plan describing functions and relationships in the health system. The Board and Chief and Council had provided direction that organization and program policies reflect a community development approach that would provide for the "greatest level of community-managed and directed health services."<sup>85</sup> They wanted to ensure that the Board was leading the health organization in a direction whereby the regional expertise of central office management and staff in PA were focused upon building and enhancing the capacity of community health centers so that eventually the local health committees and staff could govern and administer their own health services and programs by themselves.

This was in keeping with the larger political direction of the PBCN Chief and Council to make the communities of the Band more self-governing by giving them

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<sup>84</sup> PBCN Health Services Inc., Board Minutes, July 15, August 3, October 11 - 1995, Prince Albert, Sask.: 1995,

<sup>85</sup> PBCN Health Services Inc., Directional Plan, Prince Albert, Sask.: PBCN Health Services Inc., 1



more power and resources, but to do so, the Band leadership felt that this required a change in the political status of the Band to a Tribal Council. In the current situation, the Indian Affairs funding formulas were such that Tribal Councils got more funding than Bands because of the regional nature of their political organization and scope of service delivery and although PBCN was a regional multi-community Band, Indian Affairs continued to treat PBCN as a single Band with respect to its policies and global funding formulas. What the Band wanted was to be recognized as a Tribal Council by the federal government, but until they were, it was expected that the Band organizations, like PBCN Health, prepare for this eventual change by building local institutional capacities in all areas of governance and administration.

While the various program managers and executive staff were responsible for drafting the organization policies, the Board members actively participated in all phases of the process through involvement in community workshops with the health committees and staff, by directing staff to integrate past community health surveys into the plans and by helping staff gather information about other First Nation health systems including a Navajo health system model in Arizona.<sup>86</sup> Although the principles of community inclusion and accountability were universally accepted from both inside and outside the organization as fundamental guiding values for the Board to follow, there were different opinions with respect to the methods of implementation. Some felt that the community consultations were done too fast and were not inclusive enough, while others felt that the process was too expensive and time consuming, considering that there was so much operational work that needed to

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<sup>86</sup> PBCN Health Services Inc., Board Minutes, June 12-95; August 3-95; Oct 11-95; Jan 19-96; Jan 29-96, March 14-96, Prince Albert, Sask.: 1995, 1996; also reflected in the supportive statements by the leadership in the PBCN Health Services Inc., Annual Report, 1995-1996, 4, 5

be done. Nevertheless, the Board decided that the advantages of the community consultation process outweighed the disadvantages and proceeded to conduct the community consultation process while at the same time dealing with the operational issues in order of priority.

The Board direction in this matter helped to build a level of public and political confidence with respect to the legitimacy of their leadership, even though many did not agree with their methods at times. It signaled to everyone that they were committed to the principles of accountability, community control and a desire to ensure the long-term success of the organization, all aspects of what many consider to be fundamental to sustainable development in any area.<sup>87</sup> A study done by Harvard scholars, Stephen Cornell and Joseph Kalt on economic development in American Indian reservations, for example, gave support to these principles that tribal developments were most likely to succeed under conditions where there was appropriate power for making decisions (autonomy), where that power was exercised through effective institutions (capacity) and where appropriate economic policies and projects were chosen (policy-making).<sup>88</sup>

On a broader scope, in relation to creating better public policies and improving public trust, the Organization for Economic Cooperation and Development, shared a similar view as the Board in that those who governed needed to build strong relations with their public by demonstrating "commitment and

<sup>87</sup> Institute on Governance, in collaboration with York University, CESO Aboriginal Services, Saskatchewan Indian Federated College, Understanding Governance in Strong Aboriginal Communities: Phase One: Principles and Practices From the Literature, October 12, 1999, 10. Website: <http://www.iog.ca/publications/strong-ab-gov.pdf>

<sup>88</sup> *ibid*, p.i., from "Cornell, Stephen and Joseph P. Kalt, Reloading the Dice: Improving the Chances for Economic Development on American Indian Reservations, Harvard Project on American Indian Development, John F. Kennedy School of Government, Harvard University, March, 1992

leadership" to meaningful citizen participation and in spite of potentially higher costs and significant delays with no guarantee of success, the costs of not doing so could be worse.<sup>89</sup> Howlett and Ramesh also suggested that a stable policy environment, characterized by unity and partnership within the social system, was necessary for effective policy-making and implementation, and that the best situation for this was to have "both state and society to be strong, with close partnership between the two."<sup>90</sup>

Unlike most established health departments and organizations, the Board did not have the benefit of a developed organizational infrastructure to deal with the day-to-day operational issues and to allow them to do the consultations and "highly information-intensive"<sup>91</sup> policy work expected of board members. While they had the political autonomy to make and implement policies, they were also busy trying to develop the institutional capacity and expertise required to implement them. During their first year, for example, the Board averaged over 13 (two-day) board meetings and over 7 conference calls in between board meetings which was more than the 10 regular required board meetings per year outlined in their Bylaws.<sup>92</sup> This was a significant commitment of time on their part since most of the meetings were in Prince Albert and took an extra two days of traveling to get there and back. Furthermore, Board travel and honorarium costs were kept at a reasonable level, \$48,

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<sup>89</sup> Organization For Economic Co-operation and Development, Citizens As Partners: OECD Handbook On Information, Consultation and Public Participation in Policy-Making, Paris, France: OECD, 2001, 23

<sup>90</sup> Howlett Michael and M. Ramesh, Studying Public Policy: Policy Cycles and Policy Subsystems, Don Mills, Ontario: Oxford University Press, 1995, 65

<sup>91</sup> Howlett Michael/M. Ramesh in Studying Public Policy: Policy Cycles and Policy Subsystems, Toronto: Oxford University Press, 1995, 57

<sup>92</sup> PBCN Health Services Inc., Board Minutes: March 95-March 96; and PBCN Health Services Inc. Bylaws: clause V-Quorum Meetings, 1995



686 for ten board members,<sup>93</sup> by setting and adjusting Board travel policies to comparable market rates.

After the development and approval of the new operational policies, the management team coordinated a week long orientation for all staff, Board, Portfolio Councilors, and health committees in August 1995 to review the organization policies, job descriptions, code of ethics, lines of communication, to provide teambuilding workshops and to get all staff signed up for the automated payroll system and employee benefits and since many of the community staff did not have bank accounts, the direct deposit payroll system required them to open up bank accounts. An information pamphlet on the Transfer was also distributed so that people would have a better idea about the transfer and purpose of the health organization.<sup>94</sup>

One of changes with respect to payroll had to do with deductions. Prior to transfer, all Band staff were required to donate 1% from their paychecks to a Band emergency fund to be used for band members needing emergency help such as paying for funerals and so forth. However, under the health organization, transferred staff did not want to continue paying for these deductions largely because of the additional deductions associated with the group insurance plan. The Board had to make a decision whether to continue the Band practice or not, knowing that the Band administration expected them to do so. On the one hand, the Board felt a certain obligation to contribute to the emergency fund since it was used primarily to help

<sup>93</sup> PBCN Health Services Inc., Annual Report: 1995-1996, "Statement of Revenue and Expenditure for the Year Ended March 31, 1996, 26

<sup>94</sup> PBCN Health Services Inc., Peter Ballantyne Cree Nation Health Services Transfer: "Working Together Towards Healthy Families and Communities." Prince Albert, Sask.: PBCN Health Services Inc., 1995

people in need and could be considered health-related under the holistic health philosophy. On the other hand, the deduction was primarily Band policy and not necessarily Board policy, and the Board felt that the Band health staff had legitimate concerns for feeling that they could not afford to continue paying the 1% Band fee on top of all the other deductions they were required to pay. In lieu of that, the Board decided that the organization's contribution to the communities would be in the form of an annual Educational Scholarship Fund that would financially help PBCN members and high school graduates enrolled in the health-related disciplines.<sup>95</sup>

#### Hiring New Staff

The hiring processes in both PA and the community health centers were coordinated by the PA managers who followed a formalized format of advertising for two to three weeks for all the positions, preparing job descriptions, setting up interview committees in the communities to screen and recommend candidates to the Board for approval, developing standard questionnaires for the committees to use which were designed to balance the personal education and goals of the candidates, their knowledge and experience in clinic operations and their ideas with respect to community development.<sup>96</sup> There was an average of 7 people on the interview committees with 2 from the health committee, the 2 Board member(s) from the community, the health Portfolio Councilor, and 2 management employees from Prince Albert – usually the Executive Director and appropriate program manager.<sup>97</sup> By September 1995, this number was changed to a minimum of 2 community

<sup>95</sup> Assistant Executive Directors Report, September 1995

<sup>96</sup> PBCN Health Services Inc., Board Minutes, July 1995, Prince Albert, Sask: PBCN Health Services Inc., 1995

<sup>97</sup> PBCN Health Services Inc., Board Minutes, June 1995, Prince Albert, Sask: PBCN Health Services Inc., 1995

representatives (a Board and health committee member), 2 senior health staff and the Health Portfolio Councilor, with the intention to have equal numbers of senior staff and community representation making up the committees.<sup>98</sup>

In deciding who would make up the hiring committees, the Board considered the political sensitivities around local hiring processes and therefore tried to ensure that the local political and administrative authorities involved with health represented the hiring committees. Potential conflict of interest issues relating to family and personal relationships were handled by advising the participants to abstain from participating in either the vote or discussions on any of the applicants that they felt were too closely related or connected to them.<sup>99</sup>

The coordination by the PA managers in the community hiring processes in the first year was essentially an attempt to distance the operations of the organization from local politics, but the process was flexible and adapted to special cases. In one community, for example, there had been only one applicant for the health coordinator position, and because of time constraints, the Board made an exception to authorize the interview committee to interview the applicant, and if they were satisfied, to hire the person without going to the Board for approval. The only condition was that the Board had to be notified of the decision.<sup>100</sup> This process changed by the 5<sup>th</sup> year when most of the hiring in the communities were coordinated by the local managers with

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<sup>98</sup> PBCN Health Services Inc., PBCN Health Services Inc. Personnel Manual, 1995, Prince Albert, Sask.: PBCN Health Services Inc., 10

<sup>99</sup> PBCN Health Services Inc., Board Minutes, July 1995

<sup>100</sup> PBCN Health Services Inc., Board Minutes, July 1995, Prince Albert, Sask: PBCN Health Services Inc., 1995



input from the PA managers and for many positions, the authority to hire was delegated to the local committees without being ratified by the Board.

Some of the interview committee issues involved confidentiality and conflict of interest among local committee members. The PA managers developed standard questionnaires for the committees to use that were designed to balance the personal education and goals, knowledge and experience in clinic operations and community development requirements of the interviewees.<sup>101</sup> Interview committees were required to keep all discussions within the meetings confidential with all public communications and follow-up handled by the health managers,<sup>102</sup> but this did not always happen. Sometimes individual members would talk about what was said in the meetings to their family members, but rather than keeping it within the immediate family fold, the information, especially if it was negative, would be passed on to others, becoming exaggerated as it traveled throughout the community in the form of gossip, thereby causing bad feelings among different people and bringing criticism to the organization for appearing unfair in its practices. The Board tried to deal with these potential community conflicts by advising the committee members who felt they were too closely related or connected to the applicants to leave the room and to abstain from being involved in discussions relating to their family members.

#### 1<sup>st</sup> and 2<sup>nd</sup> level Management

Management decisions at the regional and community levels could be described

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<sup>101</sup> PBCN Health Services Inc., Board minutes, July 1995, Prince Albert, Sask: PBCN Health Services Inc., 1995

<sup>102</sup> PBCN Health Services Inc., PBCN Health Services Inc. Personnel Manual, 1995, Prince Albert, Sask.: PBCN Health Services Inc., 10

in terms of "levels" of decision-making with 1st level referring to community-based decisions and 2<sup>nd</sup> level to the broader overall decisions. Similar references to levels of service have been applied in various contexts in federal government documents<sup>103</sup> and scholarly<sup>104</sup> references. Health Canada suggests that community-based programs are the 1<sup>st</sup> level services, while the 2<sup>nd</sup> and 3<sup>rd</sup> levels refer to the broader (often regional) coordination, consultative and supervisory services. While these government references specifically relate to operational and service issues, they were also used to refer to various levels of governance. Jan Kooiman, in his discussion on social-political governance, described contemporary governance as a mix of governing levels, modes and orders, where "first-order governing aims to solve problems directly, at a particular level. Second-order governing attempts to influence the conditions under which first-order governing takes place."<sup>105</sup> While these references to levels could oversimplify complex interactions and portray a potentially artificial division, they do provide a useful way for describing community and regional types of services and governance.

With the hiring of the health coordinators to administer the community health centers, and the hiring of nursing coordinators to supervise the medical or clinical programs, the management component from the PA office became less direct and more in the form of supervision and consultation from the 2<sup>nd</sup> level (PA) to the 1<sup>st</sup> level (health coordinators, nursing coordinators) managers in the communities. The

<sup>103</sup> Health Canada, *Ten Years of Health Transfer: First Nation and Inuit Control*, Ottawa: Minister of Public Works and Government Services Canada, 1999, 7

<sup>104</sup> Pierre Jon, ed., *Debating Governance: Authority, Steering and Democracy*, New York: Oxford University Press Inc., 2000, from an article by Jan Kooiman, "Societal Governance: Levels, Modes, and Orders of Social-Political Interaction," 138-163

<sup>105</sup> *ibid*, 154

Director of Community Development supervised the health coordinators and the Nursing Director supervised the nursing coordinators, with additional support from the Nursing Supervisor out of PA to provide clinical training and orientation to the nurses in the communities. The Board were kept informed of community operational issues through reports from the PA managers and community health coordinators, but even with the hiring of local managers, the Board put greater reliance upon the senior managers to make regular and frequent field visits to the communities to assist the community health staff, the health committees and to attend the public meetings requested by the Chief and Council from time to time.

#### 1<sup>st</sup> level or Community-based Governance- Health Committees

The creation of 1st level or community-based health committees participating as advisors or recommending bodies was common practice under the MSB system and was carried on by the Board.<sup>106</sup> According to scholarly literature around health committees and their purposes, the committee system is common practice among First Nation governments for local policy-making.<sup>107</sup> Some committees are chaired by elected Band councilors; others are more autonomous like the PBCN health committees who selected their own presiding officers. The general idea behind the PBCN health committee system was that it provided an organized way for elected officials and in this case, the health board members, to get information and direction on local health issues and policies, but there were many concerns with respect to their roles and functions and effectiveness. For example, in the findings of a community survey that was done to evaluate the first year of Transfer, both staff and community

<sup>106</sup> PBCN Health Services Inc., Directional Plan, Prince Albert, Sask.: PBCN Health Services, 1995, 8

<sup>107</sup> Cassidy Frank, Robert L. Bish, Indian Government: Its Meaning in Practice, Lantzville, British Columbia: Oolichan Books and the Institute on Public Policy, 1989, 86, 87



respondents from the four transfer communities frequently raised issues around the usefulness of health committees.<sup>108</sup> There was a perception that the health committees "had no official duties" and while the people were aware of their existence and felt that getting more community members involved was a positive change, they "had no idea" what the committees were responsible for. Responses from various health committee members as well expressed uncertainty about their roles and authority, and while they wanted to "get more involved," they were being limited to participating at hiring interviews and being a recommending body to the Board.

The major change to local governance was that the committees had become structurally subordinate to the Board at the community level. Previously, under MSB, health committees had been considered the primary community voice on health issues and reported directly to the Chief and Council, but under the Transfer, they now had to report and account to the Board and it was now the Board's responsibility to report and deal with the Chief and Council on health matters.

Hypothetically, the committees were the communication link between the Board and the community people and were expected to provide policy input and administrative recommendations to the Board on local matters. However, because they were situated right in the communities, they were often called upon by the local health managers to assist in day-to-day operational matters. This often raised perceptions of overstepping authority and conflict of interest especially where friends and relatives were involved in local hiring processes. The Board dealt with these

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<sup>108</sup> PBCN Health Services Inc., PBCN Health Transfer Evaluation, August 1996, " Prince Albert, Sask.: PBCN Health Services Inc., 1996, 3-8

issues by providing local hiring policies that required the establishment of interview-selection committees comprised of a balanced representation of two community representatives (health board, health committee), two senior health staff and the Portfolio Councilor. Members who felt they had a real or perceived conflict of interest were asked to advise the interview committee and not participate in the decision-making, and while it was not specified, it became standard practice that this referred to immediate family members.<sup>109</sup>

While the health committees were volunteers appointed by the Health Portfolio Councilors in each of the communities and ratified by the Chief and Council, they were accountable to the Board and did not have the authority to make direct decisions on administrative matters without approval or ratification by the Board.<sup>110</sup> While the committees often felt frustrated and confused with respect to their role as advisors and wanting more input into decision-making at the local level, they went along with the process, they respected the authority of the Board because of the Chief and Council support for the Board.

Health committees were comprised of the Portfolio Councilors, the Board members and community representatives. The size of the health committees varied with the population: Pelican Narrows had 6; Deschambault Lake - 4; and Southend-4. They were comprised mostly of women in the first five years of the Transfer, a situation most probably attributable to the tendency in the communities for women to be more involved in the "social" programs areas like health and Indian Child Family

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<sup>109</sup> PBCN Health Services Inc., Board Minutes, July 15, 1995, and the PBCN Health Services Personnel Manual, 1995, Prince Albert, Sask.: PBCN Health Services Inc., 1995, 10

<sup>110</sup> PBCN Health Services Inc., 1995 draft working papers entitled, PBCN Health Committee Code of Ethics; Health Committees; and Health Committees Selection Options and Purpose, Prince Albert, Sask.: 1995

Services as opposed to the economic-oriented areas of economic development and Treaty Land Entitlement. One of the issues that the Board had to deal with was whether Health staff should sit on other PBCN regional boards due to the potential conflict of interest situations that could arise with staff sitting on governing boards, and in cases where this arose, the Board felt that it that it was in the best interest of Health not to have staff sitting on other PBCN boards.<sup>111</sup> However, with respect to other program staff sitting on health committees, the Board left the matter to the discretion of the agencies and Chief and Council and while the terms of reference for selection of health committees were never formalized by Chief and Council, it was expected that all applicants had to adhere to the same behavioral standards expected of the Board and staff of the organization which was generally to exhibit healthy lifestyles and carry out the conditions of their appointments in a prudent manner.<sup>112</sup>

Health committee meetings were organized on a regular monthly basis by the local health coordinators and were attended by the program managers from PA. Their primary role was to provide advice and support to the staff and the Board on all local health matters ranging from dealing with issues such as unsafe drinking water,<sup>113</sup> vandalism to health facilities,<sup>114</sup> interviewing local staff and setting up local workshops,<sup>115</sup> patient complaints,<sup>116</sup> problems with recruiting physicians to the communities,<sup>117</sup> interagency protocols with respect to issues like child protection and

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<sup>111</sup> PBCN Health Services Inc., Board Minutes, October 1995, Prince Albert, Sask: PBCN Health Services Inc., 1995

<sup>112</sup> PBCN Health Services Inc., Directional Plan, Prince Albert, Sask.: PBCN Health Services, 1995, 14

<sup>113</sup> PBCN Health Services Inc., Deschambault Health Committee Minutes, Oct 1995

<sup>114</sup> PBCN Health Services Inc., Director of Nursing Services Report, November 1995

<sup>115</sup> PBCN Health Services Inc., Board Minutes, October 1995; also Pelican Narrows Health Committee minutes, November 1995, January 1996, and Deschambault Health Committee minutes, March 1996

<sup>116</sup> PBCN Health Services Inc., Southend Health Committee Minutes, October 1995

<sup>117</sup> PBCN Health Services Inc., Board Minutes, November 1995;



domestic violence,<sup>118</sup> and other local health center business such as staffing and program issues.

The Program Reports for September 1995 indicated the extensive fieldwork that was done by the senior managers in Prince Albert and the heavy workloads and adjustment issues that the local health committees and staff had to manage in delivering the health services and programs in the communities.<sup>119</sup> Much of the work in all the programs such as nursing (medical treatment and health education), holistic health (addictions), community development (administration), capital (facilities, supplies), and finance was developmental requiring a lot of time coordinating program planning with the community managers and health committees, training the staff to implement the programs and coaching and assisting them throughout the process.

One community health worker who was supervised by the health coordinator from the Pelican Narrows clinic located several hours away, for example, with a small population of less than 100, staffed the health clinic in Sturgeon Landing. The nurses did regular nursing visits to the community from Pelican Narrows. The community health worker was responsible for providing both health support and addiction counseling services because of the way the funding was structured under the Transfer Agreement which provided for a half-time community health and half-time NNADAP (addictions) position in Sturgeon Landing. The community health

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<sup>118</sup> PBCN Health Services Inc., Southend, Pelican Narrows Health Committee-Interagency meetings, January 1996

<sup>119</sup> PBCN Health Services Inc., Director of Community Development Report, Sept 11-October 19, 1995, Prince Albert, Sask.; PBCN Health Services Inc., September, 1995; also Assistant Executive Director Board Report - September 1995

issues that were identified in the community included the need for assistance in health education programming, medical taxi problems, and because the community was located at the mouth of a river system, reports and tests indicated poor drinking water quality due to environmental contaminants allegedly caused by nearby mining and other developments, and inadequate garbage disposal systems.

For the larger communities of Southend, Deschambault, and Pelican Narrows, the operational and program infrastructure left by MSB helped make the transition easier in terms of having some established programs and procedures in place. The community issues reported included the need for training health committees with their planning and organizational roles, working with other program agencies to deal with concerns involving children needing treatment for solvent abuse, more programs on conflict resolution and anger management, AIDS awareness initiatives, parenting skills and so on.

There were also many personnel issues involving personal conflicts among the managers and staff attributed likely to stresses caused by adjusting to new operational rules, managing large workloads and dealing with the differing cultural perceptions and expectations between the nursing and community support staff and working in overcrowded health facilities. In Pelican Narrows, for example, the health staff had been working out of an old overcrowded clinic facility that had been too small to accommodate the needs of the community prior to moving into a much larger facility that was finished several months after the official takeover of health services by the Board. In Deschambault, there were concerns with additional workloads and shortage of space caused by the nursing program utilizing the health clinic as an orientation

site for the new nurses from the other communities. The nursing supervisor, although part of the management staff in Prince Albert, had chosen to reside in Deschambault for several months prior to moving and was therefore doing much of the central orientation for new nurses at the clinic. This was later resolved when the orientation program got more established and training was done directly in the other communities.<sup>120</sup>

Clinic expansions and new residences were later provided by MSB for the communities which helped improve the overcrowded conditions under which the staff were working. While capital projects continued to be approved and managed by MSB, Board and Chief and Council advocacy had been influential in lobbying for improved health clinic facilities. A larger building was moved to Sturgeon Landing from the Mistawasis reserve which, although not new, was larger and could accommodate both living/overnight and clinic space.<sup>121</sup> Pelican Narrows had already been in the process of getting a new clinic built even prior to the transfer process and was able to move into their facility prior to December. Deschambault and Southend were provided with renovations to their existing facilities.

Due to the drinking water quality issues that were mentioned in Sturgeon Landing and Deschambault, the Board had directed the management staff to develop a proposal to MSB for funding to deal with these issues.<sup>122</sup> At the time, the communities were under various stages of water and sewer developments. Sturgeon Landing did not have running water and people depended upon the river and lake

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<sup>120</sup> Director of Nursing Services Report August 1995

<sup>121</sup> PBCN Health Services Inc., Board Minutes, September 1995, Prince Albert, Sask: PBCN Health Services Inc., 1995

<sup>122</sup> PBCN Health Services Inc., Board Minutes, August 1995, Prince Albert, Sask: PBCN Health Services Inc., 1995



system for drinking. Boiled water notices and information were coordinated through the health clinic. Deschambault was also just getting into its sewer and water developments and people were still dependent upon private contractors for their water and sewer services. While Pelican Narrows and Southend had water and sewer lines hooked up for drinking water, they too were concerned with the water quality along their community shorelines because of the health and safety issues for children swimming in these areas. By the end of the 1995 fiscal year, a water testing lab project was set up in Pelican Narrows with a lab technician hired and trained locally to monitor the drinking water of Deschambault, Sturgeon Landing and Pelican Narrows, under the supervision of the PBCN's Environmental Health Officer. Part-time positions for Lab technicians were also hired in Deschambault and Southend.

#### Community Interagency Committees

As part of the philosophy of the community development program, the Board stressed the principles of working together and cooperation between the Health organization and staff and other program agencies in the communities such as Indian Child and Family Services, and Education.<sup>123</sup> One of the goals of the Community Development Plan was to establish interagency working groups for the purposes of "collective problem-solving, more efficient use of program funds," and for addressing the local health needs identified by the local health committees and Health Board. The Board also designated that interest revenue for the 1995-96 fiscal year be targeted to the Community Development program to be used for community projects and related activities such as staff development, community workshops and

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<sup>123</sup> PBCN Health Services Inc., Board Minutes, June 1995; also, the PBCN Health Services Inc., Community Development Program, Prince Albert, Sask.: PBCN Health Services Inc., September 1995

prevention and health promotion workshops.<sup>124</sup> By the end of the fiscal year 1995-1996, it was reported that local health managers were working with the newly developed health committees and interagency committees in the communities in joint endeavors such as conducting community public health workshops, youth conferences, regular youth and elder activity nights, winter festival projects and new initiatives such as the drinking water safety program targeting environmental health where a regional workshop was held in Prince Albert for local service contractors providing septic, maintenance, water delivery, and sanitation services to the various PBCN communities.

#### New Developments

The new developments in the first year were essentially part of the plans that the Board had with respect to meeting some of the needs identified in the pre-transfer health surveys. Although the Transfer Agreement did not address off-reserve services, the Board was faced with increasing requests by community members to provide support services in the cities. The PA managers were able to secure new program funding for a Family Services position from a provincial government grant to provide support, interpreting and other needed assistance to people coming in from the northern communities to Prince Albert for medical purposes.

There was also the Pharmacy Proposal that the Board and Chief and Council wanted to develop. The issue of stocking prescription drugs and medical supplies to the health clinics had raised problems with choosing suppliers, ordering, transportation, and keeping inventories. The past practice under MSB had been to

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<sup>124</sup> PBCN Health Services Inc., Board Minutes, September 1995, Prince Albert, Sask: PBCN Health Services Inc., 1995

order from a national drug distribution center, but with changes to that process, the Board was faced with finding alternative suppliers. The idea of a Band-owned pharmacy to handle all the medical supply needs of the PBCN health clinics was presented to the Board through a teleconference by the interim management team and portfolio councilors shortly after the inaugural Board meeting.

The Board made a motion approving the development and specified funding for a Pharmacy consulting proposal to be done with a pharmacist business consultant out of Saskatoon. The Board in making the decision to proceed with the pharmacy proposal had to weigh the risks and benefits associated with starting up a pharmacy business including the need for capital resources, pharmacy personnel, legal requirements, and the operational realities of providing services to outlying communities hundreds of miles away from Prince Albert. They were also concerned with taking on too much additional responsibility and risk in building a new business when they were just starting to build their own health organization. Nevertheless, the Board felt that the idea was a good one and needed to be investigated further.<sup>125</sup> In September 1995, the negotiations for the purchase of the pharmacy were concluded between the Band, PBCN Health Services Inc., and County Fair Management with possession date for October 1995. Each had 1/3 share in the pharmacy ownership.<sup>126</sup>

Another essential issue involved Physician contracts for doctors to deliver on-site services to the communities and to provide on-call services to the nurses in the communities on a 24 hr basis. The manager program reports in June 1995 indicated

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<sup>125</sup> PBCN Health Services Inc. Board Minutes, April 1995, Prince Albert, Sask: PBCN Health Services Inc., 1995

<sup>126</sup> PBCN Health Services Inc., Assistant Executive Director's Report, September 1995, Prince Albert, Sask: PBCN Health Services Inc., 1995



that with the difficulties associated with the road and air ambulance services to Deschambault and Pelican Narrows, it was necessary to continue to contract the transportation and physician services from the nearest hospital in Flin Flon, Manitoba. Although there was ongoing concerns with the quality of the physician services in Pelican Narrows and Deschambault, the Board and management staff had limited alternatives to pursue other recruiting sites such as Prince Albert, partly because of the shortage of physicians in the region, the isolation of the communities and by MSB policies which limited recruitment to the nearest hospital site, which for Pelican Narrows and Deschambault was Flin Flon.<sup>127</sup> Optometry Services, however, were contracted to an optometrist group out of Prince Albert with several annual field visits to the communities at the start of the school year.<sup>128</sup>

Other community issues such as water quality concerns had at least been profiled, if not resolved to some degree, with the development of the new testing services in the communities partly as a result of the Board's persistence in getting funding and partly as a result of a new national program announced by MSB to develop a safe drinking water strategy for reserves across Canada. The small lab that was set up in the larger community of Pelican Narrows coordinated the water testing in the other communities of Southend and Deschambault and although both communities desired their own labs, there was no funding to do so.

#### Highlights of 1st year accomplishments

<sup>127</sup> PBCN Health Services Inc., Board Minutes, June 1995

<sup>128</sup> PBCN Health Services Inc., Assistant Executive Director's Report, September 1995, Prince Albert, Sask: PBCN Health Services Inc., 1995

By the end of the first year, according to the 1995-1996 PBCN Health Annual Report,<sup>129</sup> PB Health had maintained a balanced budget with a surplus; hired over 60 new staff including 10 managers in the first year; hired local health coordinators and trained them to manage the clinics with the nursing coordinators providing medical and community health supervision. In relation to capacity-building in the communities, PB Health had expanded the roles and training of the community health workers beyond assisting nurses to coordinating community health and education programs. PB Health also set up local management and administrative procedures and policies for the community health centers for issues relating to personnel matters, organizing office procedures, setting up computers and computer training, and promoting community involvement in health programming. A new health facility was also built in Pelican Narrows with PB Health advising in the construction of the MSB funded health center. The new clinic was completed in the following year.

In terms of enhanced nursing training and dealing with nursing shortages, the nursing employees were required to have additional training to practice safely in their expanded roles. These included Basic Trauma Life Support (BTLS), Northern Community Nurses Program (NCNP), Northern Clinical Program (NCP) and Pediatric Advanced Life Support (PALS). In dealing with the nursing shortages, PB Health set up a nursing relief pool in addition to contracting relief services from the Nightingale Nursing Group out of Saskatoon. With respect to environmental health services, they contracted the Environmental Health Officer from the Prince Albert Grand Council to provide environmental health coverage. The standard MSB required

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<sup>129</sup> PBCN Health Services Inc., PBCN Health Services Inc., 1995-1996 Annual Report, Prince Albert, Sask.: PBCN Health Services Inc., 1995-96

medical and emergency care through nursing services and weekly physician visits were to the communities. The other mandatory services required communicable disease control programs for diseases like Hepatitis A and measles that were coordinated through contract services with a Medical Health Officer. The nursing and community staff also provided community health education through prenatal care, immunization, school and chronic disease programs.

New programs were added such as the regional Home Care program, which was designed to enhance and standardize the home care services in the communities by offering a full range of services, apart from just housecleaning, to assessment and care coordination, home nursing visits, hospital discharge planning, and respite, personal care and meal preparation. The homecare workers were also provided additional training to assist clients with medications, to do personal care and to recognize health changes in their clients. Reporting and charting systems were also developed to aid in follow up and referrals. A regional holistic health program was developed to provide standardization of mental, social and addiction counseling services and training for the staff in the communities. Holistic health staffs were integrated into the health center programs rather than being separate from the other healthcare providers. For example, 'healing the workplace' and teambuilding workshops were coordinated by Holistic Health for health staff and Board members. Other workshops for the community included anger management, suicide prevention awareness, parenting, critical incidence training, and even the Chief and Council were provided with workshops on such issues as family violence. Although urban services were not part of the Transfer, PB Health negotiated some funding from the provincial



government to offer a new urban family services program in Prince Albert to provide support services such as advocacy, translation services in hospitals, referrals, workshops, special activity projects such as Children and Treaty days for the PBCN children and families living in the city.

The enhancement of local governance capacity was achieved by setting up local health committees in each of the communities to advise the Board on local health matters. Partnerships were also established among other local service agencies through the establishment of interagency committees which were coordinated by the local health center managers for the purposes of coordinating services and jointly holding community events such as youth conferences, youth activity nights, elder's gatherings, summer camps, community cleanups, and safe drinking water initiatives. In relation to management training, for example, a joint management-training course was cost-shared between Health and various PBCN departments.

Business development to expand ambulatory services to communities was established by setting up a new ambulance service in Pelican Narrows through a business partnership between Health and PBCN Economic Development. Parkland Emergency Medical Services from Prince Albert were contracted to provide emergency medical technicians stationed at the health center in Pelican Narrows. In the area of pharmaceutical services, a new pharmacy business located in Prince Albert was set up through a joint venture purchase between Health, PBCN Economic Development and an independent pharmacist. Aside from providing general drugstore supplies to the area, the Pharmacy also supplied all the required medical drugs and other supplies for the PBCN health centers. It also provided pharmacy-

consulting services, 24 hour on call, inventory control, narcotic reviews and monitoring of stock drugs for the health centers.

### **Conclusion**

Generally speaking, the Board's governing methods were influenced by the sum of their experiences with the federal system of bureaucratic governance and by the more personalized and decentralized versions of First Nation governments. To some degree, the business-oriented approach by the Board reflected elements of the rational model of public policy and decision-making often found in government bureaucracies like Indian Affairs and MSB (Health Canada), where the development of formal institutional arrangements were intended to influence and control relationships and public behavior through contracts, administrative hierarchies, rules and procedures.<sup>130</sup> These institutional arrangements were based on the idea that problem-solving could be done through a scientific or rational process by gathering pertinent information on the problems, prescribing alternative solutions to them and then selecting the best alternative. On the other hand, the personalized political culture in the Band communities required more flexible arrangements that would accommodate a meaningful role for the community and Chief and Council to participate in policies and decisions. The various Board policy manuals and organization structure included Chief and Council representation through Portfolio Councilors, elders and community health committees throughout the decision-making

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<sup>130</sup> Pierre Jon, ed., *Debating Governance: Authority, Steering and Democracy*, New York: Oxford University Press Inc., 2000, from an article by Jan Kooiman, "Societal Governance: Levels, Modes, and Orders of Social-Political Interaction," 157; also Howlett Michael/M. Ramesh in *Studying Public Policy: Policy Cycles and Policy Subsystems*, Toronto: Oxford University Press, 1995, 139-140

spectrum of the organization. In this manner, there was a reciprocal exchange and obligation on the part of the Board and the other key players in the health system.

The roots of these formalized governing methods are found in the works of Max Weber and Frederick Taylor, both leading proponents on bureaucracies and scientific management, who played a significant influence on the evolution of the Canadian Civil Service system. Weber believed that organizations were relational bridges between the rulers and the ruled, and he promoted the establishment of control systems through an ideal type of standardized pluralistic bureaucracy with a hierarchy, unity of command, specialization of labor, written files, impersonal rules and promotion by merit.<sup>131</sup> As early as 1908, the federal government had engaged Taylor, an American engineer, to help establish universal standards of work and employment in the civil service which eventually led to the institutionalization of systematic exams, job classification systems and merit-based hiring procedures.<sup>132</sup>

Although the Board were most likely unaware of where these ideas came from, they were familiar with the MSB system of bureaucratic governance, and they knew they had to develop a professional service in order to gain public credibility, and in so doing, ran the risk of appearing to be more concerned about the business of health rather than the needs of the people.<sup>133</sup> While the Board's intention was to provide an apolitical health system which treated everyone equally through uniform standards, they also struggled to balance these more rational values of structured

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<sup>131</sup> Kernaghan Kenneth, David Siegel, Public Administration in Canada: A Text, Third Edition, Scarborough, Ontario: Nelson Canada, 1995, 41

<sup>132</sup> Kernaghan Kenneth, David Siegel, Public Administration in Canada: A Text, Third Edition, Scarborough, Ontario: Nelson Canada, 1995, 45

<sup>133</sup> PBCN Health Services Inc., PBCN Health Transfer Evaluation, August 1996, " Prince Albert, Sask.: PBCN Health Services Inc., 1996, 4



objectivity and efficiency with their own holistic and humanistic oriented political cultures which stressed "people building" through power sharing, caring and cooperation – all elements reflected in the mission and guiding principles of the organization.

This balancing was at the level of getting community involvement and awareness through a mix of training workshops, staff and health committee orientations, public meetings, and special events like youth conferences and elders' gatherings.<sup>134</sup> Encouraging community mobility was often an uphill task particularly when public meetings and community workshops often had poor attendance. Overall, however, the health transfer was considered to be a positive step with more local community staff being hired, better leadership and more health resources and technical support systems at the community levels.<sup>135</sup> It was reported that Health Services had over 60 staff members delivering the mandatory programs and services required under the Agreement along with 10 program managers at central office coordinating the overall operations. New developments were added including an ambulance service in the Pelican Narrows area and a new pharmacy in Prince Albert serving an urban market as well as the northern PBCN transfer communities; as well as new construction and renovations to the health centers in all the transferred communities to accommodate their increasing staffing requirements.<sup>136</sup> While the Board experienced what the PBCN Chief called "necessary growing pains,"<sup>137</sup> they

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<sup>134</sup> PBCN Health Services Inc., Board Meeting: April 20-21, 1995 and PBCN Health Services Inc., PBCN Health Transfer Evaluation, August 1996, "Prince Albert, Sask.: PBCN Health Services Inc., 1996, 9

<sup>135</sup> PBCN Health Services Inc., PBCN Health Transfer Evaluation, August 1996, "Prince Albert, Sask.: PBCN Health Services Inc., 1996, 12

<sup>136</sup> PBCN Health Services Inc., PBCN Health Services Inc., Annual Report: 1995-1996, 7-9, 48-52

<sup>137</sup> *ibid*, 4

had managed to balance their community and professional responsibilities through a governance process that was responsive and sufficiently flexible to meet the varying interests of all those involved in the health process.

## CHAPTER 7 IMPLEMENTATION DURING THE LAST 4 YEARS (1996-2000)

### INTRODUCTION

This chapter describes the internal and external activities, ongoing relationships, and emergent governing practices of the PBCN Health Board and administration in the last 4 years of the Health Transfer Agreement. While the same governance themes of power & authority, accountability, relationships and political culture will be covered as they were in the last chapter, relationships will be used here as the thread to illustrate how the concepts of power & authority, accountability and political culture were demonstrated. This case study is about the corporate governance of the PB Health Board and as such, is primarily concerned with the role and activities of the Board in directing the organization and how they balanced their key relationships with the 'Health Administration,' the governments (Chief & Council, MSB), the 'Community' and 'Other' agencies. Although it was not possible to recount the numerous experiences of the Board during this period of time, specific activities and situations were selected from which to discuss the main themes.

The first year was developmental and the work of the Board was mostly confined to making decisions around operational and service delivery priorities and setting up general administration policies, rather than the policy work and arms length separation from daily organization matters normally associated with boards of non-profit organizations. The remaining 4 years, however, were implementation years followed by an evaluation of the whole process, and as such, they better illustrate the more typical workings of the Board in their interactions and relationships with the



other key players in the Transfer – the PBCN Chief and Council & MSB<sup>1</sup>, health administration, community and other agencies. This chapter then focuses on these relationships to help demonstrate how the Board dealt with issues of power, accountability and political culture in the course of their work with the PBCN communities. While the key relationships are all considered to be of equal significance, more detail is spent on Board relations with the 'Health Administration' and 'Chief and Council' mostly because the Board had more direct and frequent and documented interactions with them than with the others.

### **POWER & AUTHORITY, ACCOUNTABILITY & POLITICAL CULTURE**

As a reminder, power is described here as the institutional and legal authority vested to the Board and PB Health through corporate legislation and the Transfer Agreement. It refers to the legitimate authority that people recognize and accept rather than the illegitimate authority that usually comes by way of force. It is the "power or right to give orders and make others obey or to take a specific action."<sup>2</sup> For example, the general corporate powers of boards of directors are defined as "imposing their will upon the behavior of other persons,"<sup>3</sup> which in the case of the PB Board refers to their legal powers as managers of a corporation mandated to carry out the terms of the PBCN Health Transfer Agreement. Accountability refers to the responsibility of the PB Board "to give a reckoning or explanations for (their) actions,

<sup>1</sup> Medical Services Branch, Health Canada, was signatory to the Agreement on behalf of the Minister, now changed its name to First Nations Inuit Health Branch (FNIHB) – but is referred to here as MSB.

<sup>2</sup> Hawkins Joyce M., The Oxford Large Print Dictionary, Toronto, Canada: Oxford University Press, 1989

<sup>3</sup> Gillies James, Boardroom Renaissance: Power, Morality and Performance in the Modern Corporation, Toronto: McGraw-Hill Ryerson Limited, 1992, 55

<sup>4</sup>which in their case referred to their corporate and contractual accountability to the PBCN Chief & Council as trustees of the PBCN membership and to MSB as the primary funding agency. All references relating to the Board's functions, therefore, refer to the Board's corporate rather than personal responsibilities.

Political culture was a term popularized in political science and is not specifically defined as such in the dictionary. It refers to group political orientations or "the configuration of a particular people's political orientations-that is, as the generalized belief systems of many,"<sup>5</sup> or a "particular patterned orientation toward political action (which measures) the attitudes characteristic of a national population."<sup>6</sup> The application of the term here, however, was not to try to typecast the PBCN people into some level of political development, but to simply describe the general attitudes and behaviors that were relevant to the PB Board and organization. It is an acknowledgement that community culture which suggests a "shared way of life"<sup>7</sup> and common understandings have some degree of influence in Aboriginal governance and institutional development. In other words, it was a means for describing the general political landscape or environment of the PB communities. For example, family and kinship relations are important cultural factors that impact the politics of PBCN and make up an aspect of the political culture of the PB communities. Another factor is the government status of the Chief and Council that enables them to control much of community life and over time, this power has been

<sup>4</sup> Hawkins Joyce M., The Oxford Large Print Dictionary, Toronto, Canada: Oxford University Press, 1989

<sup>5</sup> Danziger James N., Understanding the Political World: A Comparative Introduction to Political Science, Seventh Edition, New York: Pearson Longman 2005, 31

<sup>6</sup> Brodie Janine, Sandra Rein, Critical Concepts: An Introduction to Politics: Third Edition, Toronto, Ontario: Pearson Prentice Hall, 2005, 359, glossary

<sup>7</sup> Brodie Janine, Sandra Rein, Critical Concepts: An Introduction to Politics: Third Edition, Toronto, Ontario: Pearson Prentice Hall, 2005, 190

woven into the cultural fabric of the communities thus making Chief and Council government a significant influence in any local institutional development.

Political culture, in this sense, is used to describe the more significant attitudes and ideas that people hold which help shape political actions over time. Public opinion surveys, which are often used to try to measure public attitudes, tell us something about political culture in terms of general attitudes for particular situations. Public opinion is more specific and transitory, reflecting people's views about particular events or political actors or issues at a certain point in time. It is the specific character of the subjects of public opinion and the fact that public opinion can change so quickly that distinguishes public opinion attitudes from longer-term political culture orientations. In the PB case, the various pre-Transfer community surveys reflected general community support for the establishment of PB Health as a means of pursuing better health services through local self-government. These were important indicators to take Transfer and continued to influence in helping build legitimacy and acceptance in the communities where the political culture was entrenched in Chief and Council governance and administration

The official relationships identified in the PB Health Transfer Agreement involved the PBCN Chief and Council, MSB and PBCN Health Services Inc. with the coordination and management of the Agreement being mandated to the PB Health Board. All parties were seeking to better the health and well-being of PBCN members.<sup>8</sup> The Chief and Council, on behalf of the membership, were looking for

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<sup>8</sup> PBCN, PBCN Health Services Inc., Minister of National Health and Welfare Canada, The PBCN Health Transfer Agreement, 1995, PBCN Health Services Inc.: Prince Albert, Sask.: March 17, 1995, 2



long-term sustainable management and delivery of health services.<sup>9</sup> MSB, on behalf of Crown, as represented by the Minister of National Health and Welfare, was looking for the assurance that Health Services Inc. would comply with the mandatory requirements for providing health services to the designated PBCN communities and complying with the mandatory financial and program reporting requirements.<sup>10</sup> MSB viewed their relationship with PB Health as one of an "independent contractor for the sole purpose of providing a service or a program."<sup>11</sup> The Chief and Council while sharing a similar view of PB Health as an autonomous contractor saw PB Health as "their" organization delivering health services "for" them.<sup>12</sup>

The PB Board's legal authority and power to manage the PB Health organization was constituted and derived from the *Non-profit Corporations Act* of Saskatchewan and supported by its Articles of Incorporation.<sup>13</sup> It was a collective authority in the sense that individual Board members could not make corporate decisions on their own without majority Board approval. PB Health, as a legal entity, was in a contractual relationship with the federal government (MSB) and the PBCN Chief and Council through the Health Transfer Agreement<sup>14</sup> to deliver health services for PBCN, and the Board was held responsible for ensuring that the terms of the Agreement were met in a manner consistent with the organization's corporate bylaws.

<sup>9</sup> PBCN, Band Council Resolutions: March 17, 1995, "Health Services Transfer Agreement;" March 18, 1994, "Delivery of Health Care Services and Programs;" July 14, 1994, "Submission of PBCN Community Health Plans;" Pelican Narrows, Sask.: PBCN, 1994, 1995

<sup>10</sup> PBCN, PBCN Health Services Inc., Minister of National Health and Welfare Canada, *The PBCN Health Transfer Agreement, 1995*, PBCN Health Services Inc.: Prince Albert, Sask.: March 17, 1995, 7, 12

<sup>11</sup> *The PBCN Health Transfer Agreement, 1995*, s. 55, 24

<sup>12</sup> PBCN Health Services Inc., *The 1999-2000 Annual Report*, PBCN Health Services Inc., Prince Albert, Sask.: 2000, 4, "Chief's Message"

<sup>13</sup> PBCN Health Services Inc., *the Non-profit Corporations Act, 1995*, and *Articles of Incorporation*, March 10, 1995, Prince Albert, Sask.: PBCN Health Services Inc., 1995, Schedule 1

<sup>14</sup> The Minister of National Health and Welfare, The Peter Ballantyne Band, The PBCN Health Services Inc., *The Health Service Transfer Agreement, 1995*, Prince Albert, Sask.: 1995 clause 3

In carrying out these responsibilities, the Board had several main concerns: First, they

had to assure MSB and Chief and Council that the organization was being legally operated, providing efficient health services and programs and administering the finances properly. Second, they had to develop ways to fulfill their political accountability to the Chief and Council and the PBCN membership in ways that were acceptable to their political culture.<sup>15</sup> The Board was provided with the PBCN Community Health Care Plan, which was the PB Band's general health policy document, to help them implement the Agreement.<sup>16</sup> The PB Health Plan provided a governance and operational framework outlining the general roles and responsibilities of the Board in relation to the staff, community, Chief and Council, MSB and others involved in PB health care. It described the general work and scope of authority of the Board in governance terms associated with policy-making and decision making, such as "determining," "mapping," "deciding," "calculating," and "establishing." Their general duties were described as:

1. "Determining the specific structure local control will take, deciding on the formation and composition of committees and determining what specific powers they will carry.
2. Mapping out how the different sectors will be coordinated and who they will be accountable to.
3. Deciding how the resources will be distributed.
4. Determining what activities and programs will be run.
5. Determining the types of training that will be required and the duration of the various training programs.
6. Calculating the equipment and supplies required.
7. Establishing the necessary physical facilities.

<sup>15</sup> PBCN Health Services Inc., PBCN General Procedures Manual -GPM-003, February 2000, Prince Albert, Sask.: 2000

<sup>16</sup> PBCN, PBCN Community Health Care Plan, January 1995, Pelican Narrows, Sask.: PBCN, 1995

8. Establishing the required social, managerial, and technical guidance and supervision from both internal and external sources."<sup>17</sup>

It was evident at the start that a political culture reflected in the Health Care Plan favored a strong participatory role by the Chief and Council in regards to the policy direction of the organization. There was a "clear understanding that, if an Indian Health System (was) to be successfully achieved, a continued support by the leadership (was) essential,"<sup>18</sup> and more implicitly, by the role of the Chief and Council in approving Board members from the various selection processes in the Transfer communities. According to the organization bylaws, the Board had to report and be directly accountable to the Chief and Council, as trustees of the PBCN membership, for the operations of the health organization. The Chief and Council also had direct input into the policy making functions of the Board through the Health Portfolio Councilors who participated in all Board meetings, and were kept informed of the activities of the health organization through the management reports at regular Council meetings, community public meetings and the annual general meetings. The Chief and Council held these general meetings in mid July in Prince Albert where the Board provided the fiscal year-end audited financial statements and program reports of the organization,<sup>19</sup> and Chief and Council conducted voting for the Board of directors as required.

Board members were chosen from a variety of community processes, but generally most began with a call for interested ~~community~~ volunteers to fill one or

<sup>17</sup> PBCN, PBCN Community Health Care Plan, January 1995, Pelican Narrows, Sask.: PBCN, 1995, 26

<sup>18</sup> PBCN, PBCN Community Health Care Plan, January 1995, Pelican Narrows, Sask.: PBCN, 1995, 30 under "role of the PBCN leadership."

<sup>19</sup> PBCN Health Services Inc., Board Minutes, July - 1996, 1997, August 1998, July 1999, June 2000, Prince Albert, Sask.: 1996-2000



two Board positions, depending on the population. The Health Portfolio Councilors in their respective communities would then provide their recommendations to the Chief and Council, who in turn would vote, as trustees for the PBCN members, to ratify the Board through a Band Council Resolution. Board member candidacy was based upon a commonly accepted community nomination process of having people let their names stand as selected nominees for Board positions. Candidates were required to demonstrate previous experience either in business or other board or committee-related work. This previous experience was recognized in the communities as a necessary criterion to ensure the Board's success in representing the community's best interests. The selection processes reflected a political culture in the communities that was reliant upon Chief and Council to make the larger public decisions and in the case of the Board, the Chief and Council favored education and experience as the attributes for Board selection.

This political culture was carried forward into the work practices of the organization in various degrees. People still expected the Chief and Council to advocate for them even in dealing with the Board, and the Board recognizing this tendency, tried to build credibility in the eyes of the people by developing standards of practice and behavior. For example, all individuals involved with PB Health were expected to be generally accountable for their work and personal actions as long as they were involved in health. Board members, health committee members and Portfolio Councilors,<sup>20</sup> health employees, such as the local community health

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<sup>20</sup> PBCN Health Services Inc., PBCN General Procedures Manual -GPM-003, February 2000, Prince Albert, Sask.: 2000

developers<sup>21</sup> were all expected to sign confidentiality forms and agree to certain standards of public behavior. Staff, for example, could not engage in "public criticism of PB Health, Chief and Council, Board or staff, neither could they get involved in any political activities which could be interpreted as conflict of interest."<sup>22</sup> These were intended to steer the concerns of the people through official organization channels rather than going through the more personal channels of interventions by family or friends involved in the health system or appeals to the Chief and Council.

The corporate accountability of the Board to the PBCN membership was indirect through the representation of the Chief and Council at the Board level, and through various reporting forums including public annual reports, community meetings, and the work of local health committees.<sup>23</sup> For example, while the annual general meetings of the PB Health Corporation were held in Prince Albert, the Board made it a practice to direct the Executive Director and other program managers to attend community Band meetings afterwards to explain the annual report and to answer any questions arising from it. To what degree this indirect type of reporting and accountability by the Board was acceptable to PBCN members was hard to determine. Clearly, the Board had sufficient public and political support to enable them to carry on their programs in the communities, but it was also clear that people expected to be more involved. For example, support was demonstrated in the community surveys which were done for the 5 year evaluation of the Transfer from

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<sup>21</sup> PBCN Health Services Inc., PBCN Person To Person Summer Survey, August 1995, Prince Albert, Sask.: 1995, 7

<sup>22</sup> PBCN Health Services Inc., PBCN General Procedures Manual -GPM-003, February 2000, Prince Albert, Sask.: 2000, "Code of Ethics"

<sup>23</sup> PBCN Health Services Inc., Directional Plan: 1995, PBCN Health Services Inc., Prince Albert, Sask.: 1995, 14

1995-2000, where 74.5% of the 446 people interviewed from the four transfer communities indicated that "the medical services were adequate," which according to the report, strengthened and supported the work of the health organization.<sup>24</sup> In another example, the same theme of support but needing improvement was evident at a mid-transfer health conference held in Prince Albert on October 1997,<sup>25</sup> where members of the health committees and designated community elders, along with all the health staff, Chief and Council, and health Board met to review the progress and challenges of the organization. One of the key recommendations advised the Board not to give up and to continue pursuing community involvement in their programs. The repeated requests for more community input and communications through participation in the design and delivery of local health programs was a common theme. Other themes included the need to seek counsel with the youth and other community members, more training and educational workshops for community members, health committees and other local services agencies, to hold regular annual community conferences, and more elder involvement in programming.

The Board's response to these concerns was to decentralize more management authority from central office to the community health managers, and on the policy side, to provide more opportunity for community health committees to be more involved in local policies and budget decisions. For example, in a Board meeting following the mid-transfer conference, the Board requested and approved a management proposal for restructuring the organization in an effort to decentralize

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<sup>24</sup> Northern Medical Services, *Peter Ballantyne Cree Nation: Five Year Evaluation of Health Transfer*, Saskatoon, Saskatchewan: NMS, Department of Family Medicine, College of Medicine, University of Saskatchewan, December 18, 2002, 48

<sup>25</sup> PBCN Health Services Inc., *PBCN Health Services Inc., Staff Conference: Workshops on Programs, October 1997*, Prince Albert, Sask.: 1997



more management authority from the Prince Albert central office to the community level.<sup>26</sup> Since the 1995 Transfer, the health centers in the communities had been co-managed between community health coordinators and nursing coordinators – both reporting to separate directors at the central office in Prince Albert. While the structure had its advantages in terms of promoting cooperation, the separate reporting by health coordinators and nursing coordinators also caused much confusion and overlapping of responsibilities. Therefore to generate more efficiency, the senior managers recommended structural changes to streamline the reporting. Several options were presented to Board for consideration. Both essentially took away one layer of administration shifting the supervision of local health staff from the Prince Albert managers to the community health coordinators. The local health coordinator positions were reclassified to directors with revised job descriptions and increased salary grids, and rather than being supervised by the director of community development, they were now being supervised by the Executive Director.

Option #1 was to have the director of Community Development, situated at the Prince Albert central office, become the director of operations and be the direct supervisor to all staff in the various communities. Only clinical supervision over the nursing staff would remain with the nursing coordinators in the communities and ultimately, with the director of nursing services out of Prince Albert. The other program managers from central office would have more of a consultative role in their respective program areas, rather than being involved in day-to-day administrative issues in the communities. Option #2 was to have the director of Community

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<sup>26</sup> PBCN Health Services Inc., Board Minutes, October 1997, PBCN Health Services Inc., Prince Albert, Sask.: 1997

Development position remain the same, but rather than supervising health coordinators, the position would focus on developing training programs. The Board approved the recommendations by the senior managers for option #2. The reasoning was that under Option #1, the change from director of community development to director of operations would make it too hard for someone to do both administration and training, and since the Board considered the training program more of a priority, they selected Option # 2. The communities were informed about the Boards' decision to restructure the organization through a series of public meetings held later that month.<sup>27</sup>

According to the later staff reports and Annual Reports, the Board's decision to give more management authority to local health coordinators and to focus on training was successful. By December 1997, an accredited, community-based training program for community staff had been developed in partnership with the Saskatchewan Indian Institute of Technologies (SIIT), offering modules in Orientation, Basic Skills, Personal Development, Body Systems, and Indian Studies. The Prince Albert managers delivered the training modules to the community health staff in the communities for one-week, once per month rotations. Additional relief staff were hired to keep the community programs going while the permanent staff were in class. The program started with 35 students registered and by the end of three years (2000), 23 of these students completed the program and some were able to go on to pursue formal post secondary education in other health-related fields.<sup>28</sup> For

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<sup>27</sup> PBCN Health Services Inc., Board Minutes, December 1997, PBCN Health Services Inc., Prince Albert, Sask.: 1997, part of the Executive Director Report

<sup>28</sup> PBCN Health Services Inc., The 1999-2000 Annual Report, PBCN Health Services Inc., Prince Albert, Sask.: 2000, 9, Director of Holistic Health Report

example, some continued on to take nurses training under the new nursing program in Prince Albert which had been set up in the fall of 2001 through a partnership initiative with PB Health and other health agency members of the Northern Intertribal Health Authority (NITHA). The "Northern Nursing Degree Access Program" was coordinated by the University of Saskatchewan, the Saskatchewan Institute of Applied Arts and Science Technologies, the Northern Intertribal Health Authority and the Saskatchewan Indian Federated College (now First Nations University of Canada).<sup>29</sup>

Aside from training successes, community requests for input and Board responses to them were also demonstrated through efforts to get community health committees more involved in program planning and decision-making at the local level. One of the efforts was for the Board to approve a budgetary approach designating certain base funding to be distributed according to a population formula among the four Transfer communities under a section called "community-based programs." The funds were provided from an MSB program called *Brighter Futures*<sup>30</sup> and what the Board essentially did was to decentralize the management and direction of these Brighter Futures funds to the local health coordinators, who along with the staff and health committees, were able to plan and make decisions upon the yearly project and activities for their own communities, within the limits of the funding parameters as well as final Board approval.<sup>31</sup> Previously, the Board had done most of

<sup>29</sup> PBCN Health Services Inc., The 2001-2002 Annual Report, PBCN Health Services Inc., Prince Albert, Sask.: 2002, 17, Director of Nursing Services Report

<sup>30</sup> The "Brighter Futures" Program was an MSB, community-based program geared toward non-clinical programs such as solvent abuse, healthy babies, parenting skills, injury prevention, child development and mental health. Used to be a year-to-year contribution Agreement, but became part of Transfer in 1996-97.

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the planning and budget approvals on behalf of all the communities, and while they retained the final approval for the community-based annual plans, the Board did it more as a technical formality because of their financial reporting obligations under the Transfer Agreement.

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The health directors were responsible for coordinating and implementing the general decision-making process approved by the Board for community-based projects, along with the support and assistance from the central office managers to ensure that proper records, invoices and reports were maintained. The financial record keeping of the community programs, as with all health programs, remained centralized with the finance department in Prince Albert, and the major role of the health directors was to ensure that invoices and other appropriate documentation were submitted in a timely fashion for proper payments. The local approval process generally involved making yearly community project and activity plans and budgets with the staff, presenting them to the health committees for approval, and as part of the implementation, health directors had to ensure that project proposal forms were filled out by the staff in carrying out their activities and appropriate invoices kept, purchase orders made and submitted to central office for goods needed, and final reports submitted upon project completion.

The designation of community project funds by the Board helped provide more concrete opportunities for local input in community programming. Other agencies in the communities, through organized interagency groups coordinated by the health directors, were able to participate and jointly fund and coordinate many more community-wide projects such as community cleanups, Treaty/Family days,

youth and elder programs, summer camps, and various other related workshops, career fairs and conferences.<sup>32</sup> Previously, MSB had only funded positions and not the related expenditures associated with running programs. Now, with designated community funds, the staff and health committees could do better local planning and participate in broader community initiatives with other agencies. For example, summer camps provided children and youth and elders opportunities to go to summer cultural camps, to learn about healthy lifestyles and for many youth, employment in these camps.<sup>33</sup>

Although the Board supported decentralization of programs to local health committees and local administrations, they did so in a conservative manner because they were still ultimately responsible and liable for how the health services were being managed under the Transfer. The overall reporting and financial administration remained with central office under the direction of the Executive Director, and policy-making and overall decision-making remained with the Board, and the policies and decisions made by the health committees, even in the community-based programs, had to be submitted to the Board for final approval. Some of the Boards' concerns involving local capacity and the need for training had some bearing. One of the main issues had to do with the maintenance and submission of proper documentation. For example, in some cases, old bills from the previous years were being submitted to central office after the new community plans and budgets were done, thus overestimating the community projects revenue for the current year, and

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<sup>32</sup> PBCN Health Services Inc., The 1995-96, 1996-97, 1997-98, 1998-99, 1999-2000 Annual Reports, PBCN Health Services Inc., Prince Albert, Sask.: the Community Health Center reports

<sup>33</sup> PBCN Health Services Inc., The 1996-1997 Annual Report, PBCN Health Services Inc., Prince Albert, Sask.: 1997, 40-42, Pelican Narrows and Deschambault Lake Health Center Reports

resulting in timeliness issues with central office.<sup>34</sup> This was improved somewhat when health directors were required to approve all purchase orders sent to the central office and several senior managers in Prince Albert were designated to coordinate the documentation flow for the community projects program at that level.<sup>35</sup>

Notwithstanding some of the ongoing documentation issues, the decentralization of policy making and community projects was a positive step towards more local input. According to the 2003-2004 annual report, for example, the community processes were still evolving with the establishment of community project teams to coordinate the planning and delivery of the community programs, rather than just the health directors coordinating the whole process. The scope of involvement for the project teams, as well as the health committees, also expanded beyond the "community-based funding package (Brighter Futures) for programs such as solvent abuse, healthy babies, parenting skills, injury prevention, child development and mental health, to other local program funds including the Aboriginal Diabetes Initiative, Family Violence, AIDS and Home Care, and the Prenatal Nutrition Program.<sup>36</sup>

Although the degree to which the people were satisfied with the Board accountability was uncertain, it was evident that the Board had more formal reporting systems in place than MSB did to inform and gather input from the public in health matters. MSB practice for public accountability had generally been through the

<sup>34</sup>PBCN Health Services Inc., Board Minutes, August 1997, PBCN Health Services Inc., Prince Albert, Sask.: 1997, the Combined Report for Community Development and Holistic Health

<sup>35</sup> PBCN Health Services Inc., Deloitte & Touche: Report on the System of Financial Controls, PBCN Health Services Inc., Phase 1, October 1998, Prince Albert, PBCN Health Services Inc., 1998, 3; report was commissioned by the Board to review their financial control systems.

<sup>36</sup> PBCN Health Services Inc., The 2003-2004 Annual Report, PBCN Health Services Inc., Prince Albert, Sask.: 2004, 16-17, Director of Holistic Health Report



advisory functions of Chief and Council and health committees, but when the Board took over health, they, as community representatives, became decision-makers and liaisons to their respective communities, and in doing so, added more opportunities for people to participate through regular community meetings, and regional planning conferences. What was common to both MSB and the Board administrations, however, was the requirement for ongoing reporting and updating of information to the Chief and Council, and the policy requirement to have advisory input from the community health committees.

### **Internal Board Relations**

In terms of organizing their relationships among themselves, the Board developed a combination of personal and legal checks and balances. On the political side, while the Board members may have had close connections to the Portfolio Councilors who selected them from their respective communities, they could not arbitrarily make decisions by themselves on organization matters without taking them before the full Board. On the personal side, all the members of the Board and Chief and Council lived in the PBCN communities and were related to one another either through family or friendship networks and therefore, people were careful not to offend each other at Board meetings and in cases where sensitive issues, such as firings<sup>37</sup> or Executive Director evaluations<sup>38</sup> were discussed, in-camera sessions would be called where only the Board members would be present to make the decisions and

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<sup>37</sup> <sup>37</sup> PBCN Health Services Inc., Board Minutes, November, 2000, PBCN Health Services Inc., Prince Albert, Sask.: 2000

<sup>38</sup> PBCN Health Services Inc., Board Minutes, December 2000, PBCN Health Services Inc., Prince Albert, Sask.: 2000

to ensure confidentiality. This was a means of developing a kind of board discipline in matters of potential conflict and sensitivities.

The Board also balanced competing interests by developing standard organization policies and procedures based on legal guidelines identified in relevant labor and corporate legislation. The belief was that uniform principles and practices would help build a more neutral and equitable health system for everyone regardless of personal political influence or social standing.<sup>39</sup> It was an acknowledgement of the competitive nature of the PBCN political culture which, although rooted in traditional kinship-oriented values of consensus decision-making, spirituality, sharing, equitable access, cooperation, respect and hospitality,<sup>40</sup> had been changed through the years of government dependency and electoral Band politics to become less cooperative and more divided with respect to the decisions around the distribution of scarce Band-associated resources.<sup>41</sup>

The practices of the individual Board members with respect to balancing their own personal feelings and their duties to enforce policy guidelines consistently followed the majority will of the Board. For example, the Board helped clarify differences in procedural interpretations such as disagreements among interview committees with respect to the meaning of "suitability" in selection requirements and the inconsistent selection practices for the various positions, some requiring Board approval and others not. The Board direction in resolving these differences was to find more efficient methods for selecting potential employees such as interview

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<sup>39</sup> PBCN, *The Community Health Care Plan, January 1995*, PBCN, Pelican Narrows, Sask.: January 1995, 7 under "philosophy."

<sup>40</sup> See Chapter 3 of thesis, 5 to 8

<sup>41</sup> See Chapter 3, 32

scoring charts for the interviews committees to use, and changing policy requirements<sup>42</sup> delegating authority to the interview/selection committees to make the selection decisions on staffing positions, with the exception of management positions which still needed Board approval.<sup>43</sup>

#### **Board – ‘Community’ Relations (Health Committees) & ‘Other’ Agencies**

As previously mentioned, the Board relations with the ‘Community’ and ‘Other’ agencies will not be discussed individually in much detail because they were integrated into the ‘Administration’ and ‘Chief and Council’ sections. The Board-community/other relations were considered in more general terms in the Agreement requiring the Board to address “Band community health priorities,” ensure “public health and safety,” and “enhance the accountability of the Band’s health services to community members.”<sup>44</sup> Specifically, the Agreement required the Board to provide an annual report to community members, and as part of that process, “community meetings, Program reports and Audit reports” had to be completed within ninety (90) days from the fiscal year end.<sup>45</sup> The more specific references to Board-Community relations in the 1995 PBCN Community Health Care Plan were in the form of broader goals such as “bringing the authority over health issues back under local control,” and encouraging “community participation,” and “coordinated planning” in community development initiatives so that “individuals and families” could be

<sup>42</sup> PBCN Health Services Inc., The Personnel Manual, PBCN Health Services Inc., Prince Albert, Sask.: 2000, under “recruitment and hiring,” 11-12

<sup>43</sup> PBCN Health Services Inc., Board Minutes, October 1996, PBCN Health Services Inc., Prince Albert, Sask.: 1996; also in Executive Director Report, October 1996, *ibid.*

<sup>44</sup> The PBCN Health Transfer Agreement, 1995, *ibid.*, 2

<sup>45</sup> The PBCN Health Transfer Agreement, 1995, *ibid.*, 16



actively involved.<sup>46</sup> In practice, the relationships and interactions that the Board had with the community, apart from Chief and Council, was through their own informal day-to-day contacts with people in their own communities, and through their more formal participation in the health committees, community and interagency committee meetings, as well as other special meetings that they were requested to attend from time to time, such as meetings with other affiliated health agencies, and those called by the Health managers or Chief and Council.

The Board was often requested by local Health managers to assist in situations which were beyond the program capacities and scope of the clinics and staff. Aside from offering medical treatment, the goal of the Board was to facilitate community healing for individuals and families through a holistic health program aimed at preventing and reducing the psycho-social issues experienced by community members.<sup>47</sup> Holistic Health staff in particular were frequently requested by community members to intervene in specific family situations when they could no longer handle the stresses associated with addiction problems, overcrowded housing and safety concerns, but apart from the treatment and counseling services, many issues required the support of the Board in advocating with higher political authorities such as the Chief and Council and MSB.<sup>48</sup> For example, requests for long-term care facilities for the elderly, outdoor recreation equipment, alcohol and drug treatment

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<sup>46</sup> PBCN, PBCN Community Health Care Plan, January 1995, Pelican Narrows, Sask.: PBCN, 1995, 25

<sup>47</sup> PBCN Health Services Inc., in a workshop document entitled, Health Transfer Preparedness, PBCN Health Services Inc., Prince Albert, Sask.: April 26-30, 1999, Appendix 7a, "Community Projects."

<sup>48</sup> PBCN Health Services Inc., Annual Reports: 1995 to 2000, PBCN Health Services Inc., Prince Albert, Sask.: 1995 to 2000, under "Holistic Health Report."

facilities, better housing, funding for new reserves and health services for off-reserve members.<sup>49</sup>

The Board relations with the local health committees were primarily through their participation as members in the local health committees and through their monthly committee meetings. The meetings usually covered a wide range of concerns and activities from local operational and personnel issues to program planning and budgeting, and local policy-making. The Board's practice from the beginning of Transfer was to delegate certain decision-making authority to the health committees on issues involving the planning and allocation of community-based grants. These included local projects targeting youth, elders, families and children through a broad range of services from summer camps and youth employment programs, solvent abuse, healthy babies, parenting skills, injury prevention, mental health and child development.<sup>50</sup> The internal funding distribution to the community clinics for community projects was population-based with 50% going to the largest community, Pelican Narrows, 24% going to Deschambault and Southend and 2 % going to Sturgeon Landing.<sup>51</sup>

The health committee members received a small honorarium for their committee work and because they often dealt with matters of a confidential nature, they were required by the Board to sign an oath of confidentiality and to abide by the code of ethics expected of Board members.<sup>52</sup> Some of the other tasks besides program

<sup>49</sup> PBCN Health Services Inc., PBCN Health Services Conference, January 28-30, 2003, Prince Albert Sask.: PBCN Health Services Inc., 2003

<sup>50</sup> PBCN Health Services Inc., Board Minutes, Prince Albert, Sask.: July 10, 1995. Sept 2000

<sup>51</sup> PBCN Health Services Inc., Executive Directors Report, March 1998, PBCN Health Services Inc., Prince Albert, Sask.: 1998, slight adjustment was made in the original distribution formula from 53% PN, 21.5% for DL and SE and 2% for S.L.

<sup>52</sup> *ibid*, September 1998

and budget planning, included approving local capital requests and purchases for the clinics, staff interviews, attending various conferences, dealing with environmental issues (garbage disposal sites, water and sewer, safe swimming areas, boating safety, community cleanups), and advocating for ways to deal with health-related issues such as poor housing, alcohol and drug abuse, and family violence.<sup>53</sup> While the formal role of the health committees was to advise the Board through recommendations, there were some gray areas with respect to the separation between the advisory and operational functions of the committees and procedural concerns around such things as the number of health committee members attending interviews.<sup>54</sup>

The community meetings were open public meetings organized by the Chief and Council on a semi-regular basis (quarterly) where Board members and management staff were expected to provide documented reports and help Council address health-related community issues. Some examples of health issues raised included transportation and taxi issues, wood stove irritants and/or molds in houses creating unhealthy living environments (asthma and respiratory conditions), alcohol, gas sniffing and drug-related issues especially with youth, elder care issues, curfews, and specific patient concerns. Often the Chief and Council would provide requests to the various PBCN program managers, including health managers, to work together in developing joint projects to address various community issues such as developing foster homes, senior care homes and programs. The Executive Director for follow-up would report these requests to the Board for their advice and decision.<sup>55</sup> Local

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<sup>53</sup> PBCN Health Services Inc., Executive Directors Report, July 1998

<sup>54</sup> *ibid*, March 1999

<sup>55</sup> PBCN Health Services Inc., Executive Director Report December 1996, PBCN Health Services Inc., Prince Albert, Sask.: 1996



Interagency committees were also organized and coordinated by the local health directors for improving communication, pooling resources and working together for the general development of the community. Some of the issues included developing protocols for dealing with situations involving the RCMP, Indian Child and Family Services, Education, and the Band administration; planning and sponsoring joint community workshops, conferences and annual projects such as summer youth and elder camps; and cost-sharing administrative projects like community security services.<sup>56</sup>

The Board relations with 'Other' agencies in the Transfer Agreement were limited to references by other First Nation agencies involved in some aspect with PBCN, such as the agreement to have the Prince Albert Grand Council continue to deliver Environmental Health Services to PBCN,<sup>57</sup> and the agreement for PB Health to provide nursing services to the members of the Lac La Ronge Indian Band living in the close community of Brabant Lake and to "work cooperatively" with the La Ronge Band towards agreement on this delivery. Other references had to do with impacts by other Band developments, such as the Treaty Land Entitlement process, where the Minister or MSB agreed to help the Band identify and make the "appropriate links" with the province of Saskatchewan to address the delivery of health services for Band members on "newly designated Band Lands," or new reserves previously serviced by Saskatchewan Health.<sup>58</sup>

<sup>56</sup> PBCN Health Services Inc., *Annual Reports: 1995 to 2000*, PBCN Health Services Inc., Prince Albert, Sask.: 1995 to 2000, under the reports by the "Executive Director," and the "health center" reports from Pelican Narrows, Deschambault Lake and Southend.

<sup>57</sup> *The PBCN Health Transfer Agreement, 1995*, *ibid*, s.11, 9

<sup>58</sup> *The PBCN Health Transfer Agreement, 1995*, *ibid*, s.2, 4

Relations with outside businesses and appropriate regulatory agencies were also mentioned where PB Health agreed to "enter into a contractual arrangement with a pharmaceutical firm for the purchase of its drugs and medical stocks," and follow all the appropriate regulations of the "Narcotic Control Act and Criminal Code and the Food and Drug Act." <sup>59</sup> Others included the hiring of "an independent auditor to conduct an annual comprehensive financial and program audit" according to generally accepted accounting principles. <sup>60</sup> Other relations relating to "outside agencies" were also mentioned in the PBCN Community Health Care Plan where caution was advised for PB Health to ensure that control remained at the local level and not be appropriated by those on the outside in the name of "efficiency, accountability or expertise." <sup>61</sup> The kind of relations envisioned with outside agencies was for PB Health to control the use of these resources according to the local community health priorities.

The affiliations with other provincial and national First Nation and "other" health agencies were considered important for enhancing services. The Board, through the organization, became involved as a partner in a third level health service agency with other northern First Nations. The Northern Intertribal Health Authority (NITHA) was established to provide third level (specialized programs and advocacy) support to the partner agencies on issues relating to their transfer agreements and

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<sup>59</sup> The PBCN Health Transfer Agreement, 1995, s.12, 9

<sup>60</sup> The PBCN Health Transfer Agreement, 1995, s.32, 16

<sup>61</sup> PBCN, PBCN Community Health Care Plan, January 1995, Pelican Narrows, Sask.: PBCN, 1995, 25-26

specialized health services such as the Communicable Disease Control Program and the Medical Health Officer.<sup>62</sup>

While many First Nations were wary of being integrated into provincial health reforms through their participation in regional health districts because of fears of potentially compromising their treaty rights to health, some like PBCN, believed that their Treaty Rights would not be jeopardized because of the Treaty protection clauses in their Agreements, and that it was potentially more beneficial to participate in the health boards and have input into the regional decision-making.<sup>63</sup> In April 1997, discussions with the other northern First Nations resulted in recommendations for participating in the 2 new health districts in the north.<sup>64</sup> In August 1997, the PBCN Chief and Council appointed two health Portfolio Councilors to be appointed as board members to the Mamawetin Churchill Health Authority located in La Ronge.<sup>65</sup> The Board was also supportive of the organization being affiliated with other provincial health agencies in order to access additional health education, resources and personnel training opportunities and held an associated membership with the provincial Saskatchewan Association of Health Organizations.<sup>66</sup>

#### **Board-Administration Relations – 1<sup>st</sup> and 2<sup>nd</sup> level Services**

The Board - Administration relations were also generalized in the Transfer Agreement where PB Health agreed to manage and deliver health services according

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<sup>62</sup> PBCN Health Services Inc., Annual Reports 1996, 2000, PBCN Health Services Inc., Prince Albert, Sask., 1996, 2000

<sup>63</sup> Health Canada, Medical Services Branch, Long-Term Evaluation of Transfer: Final Report, October 1995, Ottawa: Institute for Human Resources Canada, 1995, 50

<sup>64</sup> PBCN Health Services Inc., Board Minutes: April 1997, PBCN Health Services Inc., Prince Albert, Sask.: 1997

<sup>65</sup> *ibid*, August 1997

<sup>66</sup> PBCN Health Services Inc., Board Minutes: March 1996, PBCN Health Services Inc., Prince Albert, Sask.: 1996



to "the objectives and activities described in the PBCN Community Health Care Plan,<sup>67</sup> and in a provision relating to PB Health representation which stated that "the Executive Director" would be the "Health Services Inc.'s representative for the purposes of the Agreement."<sup>68</sup> The Community Health Plan set out the governance structure according to the non-profit corporation model of a policy Board directing the administration through the management coordination of an Executive Director.<sup>69</sup> The Board was officially responsible for making administration and personnel policies and making decisions on larger administration and politically sensitive matters.<sup>70</sup> The Executive Director and program managers were held responsible for implementing and enforcing Board policies<sup>71</sup> and ensuring that Board approval was secured for major decisions<sup>72</sup> such as those involving high costs, changes to policy directions and the hiring (and firing)<sup>73</sup> of management staff. The lines of accountability with respect to supervision and reporting relationships were outlined in the PBCN Health organizational chart.<sup>74</sup>

The management of the organization was structured into two levels – one at the 1st or community level through the health directors and nursing coordinators and the other at the 2<sup>nd</sup> level or central office in Prince Albert which provided management and other technical support services through the Executive Director and

<sup>67</sup> The PBCN Health Transfer Agreement, 1995, *ibid.*, 4

<sup>68</sup> The PBCN Health Transfer Agreement, 1995, *ibid.*, 23

<sup>69</sup> PBCN, PBCN Community Health Care Plan, January 1995, Pelican Narrows, Sask.: PBCN, 1995, 27-32

<sup>70</sup> PBCN Health Services Inc., Health Administration Manual, Sept. 1995; Revised February 25, 2000, PBCN Health Services Inc., Prince Albert, Sask.: 2000, 1 of *General Procedures*

<sup>71</sup> PBCN Health Services, The Personnel Manual 2000, PBCN Health Services Inc., Prince Albert, Sask.: 2000, 37 under "disciplinary action."

<sup>72</sup> PBCN Health Services, The Personnel Manual 2000, PBCN Health Services Inc., Prince Albert, Sask.: 2000, s. 7, 10 – ED has a duty to ensure that all management recommendations be ratified by the Board.

<sup>73</sup> The Personnel Manual 2000, *ibid.*, 39 under "termination for cause."

<sup>74</sup> see attachment

various central program managers. The personnel provisions dealing with the management structure went through several changes in 1995, 1998 and 2000. During the first two years of the Transfer, the Personnel manual indicated that the central management team led by the Executive Director was responsible for implementing the personnel policies and providing direction to the community managers.<sup>75</sup> At the time, the management team consisted of 10 program managers from Prince Albert who were under the immediate supervision of the Executive Director. These included the Assistant Executive Director, the Executive Clerk, the Nursing Director, Nursing Supervisor, Director of Community Development, Home Care Coordinator, Director of Holistic Health, Capital Manager, Family Services Coordinator, and Business Manager.

The management style of decision-making was based on a team approach where the program managers and Executive as a group made the overall program and operational decisions of the organization as delegated by the Board.<sup>76</sup> It was surmised that the team approach would provide more informed decisions and a more equitable method of sharing the workload among the program managers.<sup>77</sup> With respect to management accountability and communications to the Board, each of the program managers were required to provide and present their progress reports at the regular monthly Board meetings along with the Executive Director.

<sup>75</sup> PBCN Health Services Inc., The Personnel Manual, 1995, Prince Albert, Sask.: 2000, 9 under "accountability." This was revised in 1998 and again in 2000.

<sup>76</sup> PBCN Health Services Inc., The 1995-1996 Annual Report, PBCN Health Services Inc., Prince Albert, Sask.: 1995-1996, 7

<sup>77</sup> PBCN Health Services Inc., Executive Director Report, January 1996, PBCN Health Services Inc., Prince Albert, Sask.: 1996

By 1998 and 2000, the management team had changed to 8 program managers with the structuring out of the Director of Community Development and Assistant Executive Director positions to accommodate the Board's direction to decentralize more administrative responsibility to the community level.<sup>78</sup> The decentralization from central office to the community clinics was done through the expansion of the roles of the health coordinators to health directors with direct accountability to the Executive Director rather than through the Director of Community Development. The 3 community-based health directors thereby became responsible for the overall 1<sup>st</sup> level health services managing the day-to-day operations of the various health clinics, and since they were now elevated to senior management positions, they became part of the 2<sup>nd</sup> level or central office management team with direct accountability to the Board through regular progress reports at the Board meetings.

The hiring of community health directors was also a shift from the previous MSB practice of having the nurses-in-charge managing the health clinics. It was also a shift from the first several years of PBCN health operations where local clinics were managed under a co-management idea where the health and nursing coordinators shared the responsibilities associated with day-to-day operations and while it had positive aspects with respect to promoting cooperation and integration, it also resulted in much confusion and overlapping of responsibilities. With the structural change from health coordinators to health directors, the nursing coordinators became answerable to the health directors for administrative issues although they were still responsible for the overall clinical supervision and medical treatment services.

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<sup>78</sup> PBCN Health Services Inc., PBCN Board Minutes, Prince Albert, Sask.: Oct 1997



The management team and Executive Director were provided a significant amount of influence and power in the administration of the organization and in Board decision-making through delegation by the Board to deal with day-to-day operations and by managing the flow of information to the Board and providing strategic recommendations.<sup>79</sup> The communication and office politics (ie maneuvering for power) between the managers and the Board was primarily filtered through the Executive Director as a matter of policy.<sup>80</sup> The checks and balances upon the power of the Executive Director were through performance evaluations by the Board, the ethical guidelines under the code of ethics, the personnel and administration policies, and a requirement that all recommendations brought to the Board by the Executive Director have the majority support of the management team.<sup>81</sup>

The Board experienced some challenges in the first several years of operation in maintaining a consistent management team. One of the concerns expressed by the staff and community in an internal survey in 1996 was the amount of turnover at head office in Prince Albert which made it hard for them to feel "confident with one's own position when there is such an abundance of change at the main office."<sup>82</sup> The Executive Director position went through 3 changes between 1995 and 1997, and the director of nursing, finance, and holistic health positions also made several changes in that period, but from there to 2000, a consistent management team emerged.<sup>83</sup>

<sup>79</sup> PBCN Health Services Inc., The Personnel Manual, PBCN Health Services Inc., Prince Albert, Sask.: 2000, 9-10

<sup>80</sup> PBCN Health Services Inc., The Personnel Manual, Prince Albert, Sask.: 2000, 9, (Sept 1, 1995; revised Oct 19, 1995; Sept 25, 1998 and Feb 25, 2000)

<sup>81</sup> *ibid.*, 10 under "management team."

<sup>82</sup> PBCN Health Services Inc., PBCN Health Transfer Evaluation, August 1996, PBCN Health Services Inc., Prince Albert, Sask.: 1996, 11

<sup>83</sup> PBCN Health Services Inc., Annual Reports, 1995 to 2000, PBCN Health Services Inc., Prince Albert, Sask.: 1995 - 2000

In 1995 to 2000, the program and support staff of PBCN Health grew from over 60 to over 80 staff in the communities. There were over 20 staff in Pelican Narrows serving a population of over 3000 people with an average number of 1800 clients seen per month to as many as 3400 in November 1995 and by 2000, over 35 permanent and 10 relief staff were employed. In Deschambault Lake, a population of over 1000, over 13 staff served over an average of 1200 people per month in the treatment and public health programs, and in 2000, the clinic reported 18 staff serving an average of over 1400 clients per month. In Southend, a community of over 1000, had 13 staff in 1995 serving up to 1200 people on average per month in their treatment and public health programs and in 2000, reported 18 staff seeing an average of 1100 people per month.<sup>84</sup> About 80% of the clinic staff were Band members and employed mostly in the non-nursing positions, and with respect to management positions, 4 out of the ten program managers plus all the health directors were Band members.

With the growth in personnel at the community level and the need for developing teamwork and good morale, the Board approved budgets for annual staff conferences which provided another means of organizational accountability and direction for the management and Board. The conferences were inclusive of all the major players in the health system including all the staff, community elders and youth, health committees, and Chief and Council. These large forums provided opportunities to review the performance of the organization as a whole and to

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<sup>84</sup> PBCN Health Services Inc., Annual Reports, 1995 to 2000, PBCN Health Services Inc., Prince Albert, Sask.: 1995 – 2000, under community reports

recommend future directions.<sup>85</sup> For, example, the theme of the 1996-1997 conference, "caring for our workplace, caring for ourselves, caring for our community," reflected a common desire to build teamwork and holistic values into the health system.

Workshop topics covered mental health, non-insured health benefits, home care, environmental/occupational health, community health education programs, community health nursing, holistic health programs, and communicable disease control.<sup>86</sup> According to the evaluations of the conference, most were pleased and supportive of the direction of the organization. Their suggestions for improvement included having the Board listen to the people and advise the clinic staff and for managers to have more staff and health committee development in the communities, for community staff to have more home visits, more assistance with teamwork, clearer job descriptions and more workshops on healing and personal counseling.<sup>87</sup>

The more common personnel issues that developed during the evolution of the organization had to do with matters of employee discipline, different cultural perceptions and kinship factors among local staff, confidentiality issues, staff complaints regarding management and Board decisions. The more common operational issues had to do with the management reporting of unusual situations to the Board's attention, internal operational reviews, participation in external committees and boards, local protocols for clinic closures for community events and funerals, physicians services, recruitment and retention of medical personnel

<sup>85</sup> PBCN Health Services Inc., Annual Reports 1996 to 2000, PBCN Health Services Inc., Prince Albert, Sask.: 1996 to 2000

<sup>86</sup> PBCN Health Services Inc., PBCN Health Services Inc., Mid Transfer Conference, October 1997, Workshops on Programs, PBCN Health Services Inc., Prince Albert, Sask.: 1997

<sup>87</sup> PBCN Health Services Inc., Conference Evaluation 1997, PBCN Health Services Inc., Prince Albert, Sask.: 1997



including nurses, pharmacists, dental therapists, and relations with business partnerships.

#### More Common Personnel Issues

1. Matters of employee discipline – verbal warnings, written warnings, suspensions, terminations<sup>88</sup>

Most matters of employee discipline at the community level were coordinated by the health director and reported to the Executive Director, the local Board members and health committees for information purposes and consultation. The Executive Director was responsible for the coordinating the disciplinary processes involving the administration employees and program managers at the central office in Prince Albert, and these were reported to the Health Board Chair and Board. With respect to discipline involving the Executive Director, the Board Chair and a designated senior manager would coordinate the process under the consultation and direction of the Board.<sup>89</sup> The Board also was responsible for an annual job evaluation of the Executive Director and these evaluations were done in camera with each of the Board members completing an evaluation form, and then reviewing the general outcomes afterwards with the Executive Director.<sup>90</sup>

The intention of the discipline policy was to ensure a progressive corrective measure for improving employee performance with flexibility provided for extenuating circumstances. There were 4 steps to the process – 3 recorded verbal warnings, a written warning filed in the employee's file, and either a suspension or

<sup>88</sup> PBCN Health Services Inc., The Personnel Manual, Prince Albert, Sask.: 2000, 37

<sup>89</sup> PBCN Health Services Inc., Board Minutes March, August 1998, Prince Albert, Sask.: 1998

<sup>90</sup> PBCN Health Services Inc., Board Minutes March, 1999, Prince Albert, Sask.: 1999

termination as authorized by the Executive Director. Some of the situations that gave rise to the disciplinary provisions and were taken to the Board and their legal counsel involved supervision issues such as perceived insubordination or refusal to do instructed tasks, being chronically late for work, absenteeism, perceived breaching of the code of ethics or confidentiality requirements, allegations of drinking while on duty and other actions considered to be disrespectful of the organization and Chief and Council.<sup>91</sup>

The management direction from the Board in resolving these situations was to deal with facts and documented evidence of work performance and behavior and not rumors or stories. While the Board was usually not involved in the disciplinary process, there were cases when the Executive Director would bring what were considered unusual or highly sensitive cases to the Board, such as those concerning close relatives of individual Board members and political leaders. In these cases, the affected Board member(s) would express a potential conflict of interest and leave the meeting until the matter was decided upon and in many instances, the Board was split in their decisions, but the majority vote always prevailed.<sup>92</sup>

The perceived insubordination situations often developed from employees not following operational and financial procedures as directed by the supervisors or timing issues, not getting work projects done on time. The requirement to have all purchase orders authorized from central office for goods and supplies bought by the community managers and staff was one example. According to an internal financial

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<sup>91</sup> PBCN Health Services Inc., The Personnel Manual, Prince Albert, Sask.: 2000, 38, (Sept 1, 1995; revised Oct 19, 1995; Sept 25, 1998 and Feb 25, 2000)

<sup>92</sup> PBCN Health Services Inc., PBCN Board Minutes, Prince Albert, Sask.: October 1996, March, April May, 1997

control analysis in 1998, there were some issues with unmatched purchase orders from the communities and recommendations were made to the Board for a better system for tracking purchase orders and invoices with receipts.<sup>93</sup> Following that report, the second phase report in 1999 indicated that timeliness issues still needed improvement, but overall, there were improvements with the implementation of most of the earlier recommendations.<sup>94</sup> There had been concerted efforts by the local managers and staff to follow the administrative and financial policies following the first report and the Board had also contracted a consultant to help implement the financial control recommendations and had hired an additional accounting position in the finance department.<sup>95</sup>

Another example was absences from work without notification to the supervisor and/or authority from the supervisor.<sup>96</sup> While most of the concerns were generated and resolved by the managers from the health clinics, some also came from outside the clinic settings from Board members, Portfolio Councilors, health committee members and sometimes the general public who would report staff allegedly not attending workshops or being at work when they were supposed to and being seen in other places not connected to work duties. Timeliness issues were also raised frequently such as staff being chronically late for work and not getting to required meetings and public events on time, thus creating feelings of resentment internally among other staff who were on time and with those from the outside

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<sup>93</sup> Deloitte & Touche, Report on the System of Financial Controls, Peter Ballantyne Cree Nation Health Services Inc., Phase I: October 1998, PBCN Health Services Inc., Prince Albert, Sask.: 1998, 8

<sup>94</sup> PBCN Health Services Inc., PBCN Board Minutes, Prince Albert, Sask.: December 1999

<sup>95</sup> March 1999

<sup>96</sup> PBCN Health Services Inc., PBCN Board Minutes, Prince Albert, Sask.: April 1996



attending the meetings and events.<sup>97</sup> The timeliness complaints were generally only raised where chronic behavior patterns were observed by the managers and were negatively affecting the work performances of the employees.

The Board also dealt with their own issues of timeliness when attending meetings through informal board discipline with the Chair or elder or other Board members reminding others that unless there were extenuating circumstances, they were to cooperate and keep to their scheduled meetings.<sup>98</sup> The timeliness issues of the employees were addressed through changes in the Personnel manual code of ethics. In 1995, for example, the broad reference to the requirement for employees to "carry out the conditions of employment honestly, conscientiously and loyally," was expanded by specific references for employees to "report to work regularly and on time every scheduled working day unless prior arrangements are made with the immediate supervisor."<sup>99</sup>

## 2. Different cultural perceptions and kinship factors between local staff<sup>100</sup>

The disagreements between local staff, in particular between nurses and other health staff from the communities, usually had to do with differing perceptions and understandings of how things should be done, reciprocal feelings of isolation, exclusion, and not being appreciated arising from such things as separate meetings, lack of communication and information sharing, timeliness for meetings, questions

<sup>97</sup> PBCN Health Services Inc., PBCN Board Minutes, Prince Albert, Sask.: April, 1996., March 1998, October 2000

<sup>98</sup> PBCN Health Services Inc., PBCN Board Minutes, Prince Albert, Sask.: March 1998

<sup>99</sup> PBCN Health Services Inc., The Personnel Manual 1995, 2000, PBCN Health Services Inc., Prince Albert, Sask.: 5 (1995), 3 (2000)

<sup>100</sup> PBCN Health Services Inc., PBCN Board Minutes, Prince Albert, Sask.: April, October (1996), March, April, May, Oct (1997), February, August, (1998), August, (1999) – common issues around discipline

over the nature and quality of client services and individual personality clashes.<sup>101</sup>

The Board direction was for supervisors and management to work on a team atmosphere in the health clinics and to provide the appropriate assistance and supports such as counseling where needed.

The health clinics were open regular work hours and for emergency services 24 hours a day, 365 days a year and the extra workloads on certain staff like the managers, nurses and mental health and addictions counselors, were cited as the probable reasons for some of the problems.<sup>102</sup> The various situations were usually resolved through the coordination of the local managers with support from the central office managers and the advice of either the board members, health committee members and portfolio councilors, particularly in politically sensitive cases involving the treatment of family members, people with serious illnesses, elders, children and emergencies.

The disagreements between the nursing and community staff often placed the local managers in opposition. While the 1997 restructuring allowed for more local management autonomy, it also created some confusion among the staff over what were considered clinical versus administrative issues. In some cases, the issues over local management were addressed through innovative measures such as in Pelican Narrows where a local management team was set up in the clinic to help "make joint decisions in the general functioning of the Center,"<sup>103</sup> but in most cases, the

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<sup>101</sup> *ibid*, February, April, May, 1997; also in PBCN Health Services Inc., Director of Community Development Report December 1995-January 1996; Also, Executive Director Report, December 1996

<sup>102</sup> PBCN Health Services Inc., Director of Holistic Health Report, November 1995-January 1996, PBCN Health Services Inc., Prince Albert, Sask.: 1996

<sup>103</sup> PBCN Health Services Inc., Annual Report, 1998-1999, PBCN Health Services Inc., Prince Albert, Sask.: 1998-1999, 15

uncertainties continued but were managed in large part by the managers themselves with support from the local Board members and Portfolio Councilors and from directions given by the nursing director and Executive director in Prince Albert.

Other issues between the local managers involved disagreements over appropriate disciplinary measures and work procedures where either the nurses or other staff would raise issues about inappropriate public behavior, such as perceived loud and negative comments in a public place about nurses from co-workers from the community, particularly when treating their family members, complaints by community staff regarding perceived negative attitudes and behavior by some nurses towards them and to patients, or complaints by either regarding not sharing their team workloads in the health programs. In other cases, letters of complaint from the communities would raise issues regarding alleged negative social behavior of staff outside working hours (ie., alcohol and drug use, fighting) and not being proper role models for the organization.<sup>104</sup> While there was no clear policy as to what negative behavior entailed other than extreme circumstances involving criminal activities, and while decisions had to be balanced between presenting a positive public image as a staff member or Board member and invading the personal privacy rights of individuals, the policy and practice of the Board was that, unless the private actions unduly affected work performance, they had no authority over their private lives of the staff.

3. Alleged breaches of confidentiality by staff usually triggered by community complaints and/or by the staff.<sup>105</sup>

<sup>104</sup> PBCN Health Services Inc., Board Minutes December 1997, PBCN Health Services Inc., Prince Albert, Sask.: 1997

<sup>105</sup> PBCN Health Services Inc., Board Minutes April 1996, PBCN Health Services Inc., Prince Albert, Sask.: 1996



Most complaints regarding breaches of confidentiality were at the community level and had to do with allegations of staff revealing private and confidential information to the general community or their families. Aside from the legal requirements for patient privacy and security of patient records, the oath of confidentiality provisions were broad generalizations for staff to keep in "strictest confidence any and all information in relation to the business affairs and operations of the PBCN Health Services."<sup>106</sup> The broad scope created many gray areas with respect to what was private and public information and provided management with broad discretionary authority in determining which situations constituted a breach. In all cases recommended terminations due to breach went to the Board and in the five-year period, there were no terminations specific to breach and neither was the oath of confidentiality changed which suggests that either the provisions were so broad that it was hard to prove specific situations, or even if there was some evidence, that other disciplinary measures were followed aside from termination, or that the investigation processes were so stressful and politically sensitive that the managers and Board were reluctant to take extreme measures. In any case, confidentiality issues have been and continue to be a concern by communities with respect to both community health workers "when speaking to their relatives about who's sick and what's wrong with people," and nursing staff for "less gossip and more confidentiality."<sup>107</sup>

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<sup>106</sup> PBCN Health Services Inc, *The Personnel Manual*, 2000, Prince Albert, Sask.: 2000, 3

<sup>107</sup> PBCN, *The Health Care Needs Assessment For The Members of the PBCN Living at Deschambault*, PBCN, Pelican Narrows, Sask.: July 1991, 34 and *Southend*, 35, both under "Desired Changes to the Present Health Services," respectively.

#### 4. Staff complaints regarding management or Board decisions.<sup>108</sup>

Often letters came to central office outlining certain staffing concerns about managers and their decisions, but there were also cases when letters were circulated among the community clinics and routed through the health directors or nursing coordinators prior to being referred to the Executive Director. The direction of the Board in these matters was to follow the proper procedures, and since the circulating of negative letters among staff for the purposes of inciting support was considered unprofessional and political behavior, formal letters usually followed indicating Board disapproval for not following the proper channels for communication. Staff complaints against Board decisions were more common in the first few years of operations and were generally in the form of rumors against perceived unfairness practices in the organization. The general policy and practice of the Board with respect to rumors or gossip was to require formal letters of complaint, although matters brought up by individual Board members or Portfolio Councilors would be discussed and reviewed privately (*in camera*), but even these required documented evidence for any formal actions to commence.<sup>109</sup>

Staff complaints with respect to administrative issues were largely resolved through the program managers who would raise concerns such as wage parity issues to the Board. In 1997, for example, the management team, in response to community staff complaints regarding wage disparities and the lack of annual increments to their salaries to adjust for inflationary factors, reviewed the salary grids and recommended

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<sup>108</sup> January 1997, also PBCN Health Services Inc., The Administration Manual, also called the General Procedures Manual 2000; Prince Albert, Sask.: 2000, page 2

<sup>109</sup> PBCN Health Services Inc., Board Minutes March 1998, PBCN Health Services Inc., Prince Albert, Sask.: 1998

options for the Board's consideration. The Board approved the management recommendations for salary grid increases to bring parity between the community staff and other local Band agencies, and to provide for cost of living increases.<sup>110</sup>

#### More Common operational issues

##### 1. Unusual Occurrence Reports<sup>111</sup>

The unusual occurrence reports that reached the attention of the Board were usually things that were considered unusual from the day-to-day operations of the organization with potential political or legal implications. The procedure was for the community managers to report what they considered serious cases to the appropriate central office managers for resolution and to keep the Board informed. These were far ranging because there were no clear guidelines as to what "unusual actions" were, so these were left to the discretion of the local managers. Some examples in 1995- 2000 included personnel issues; investigations by other local agencies involving the clinics, usually Social Services and the RCMP, in situations dealing with child protection issues under the Child and Family Services Act. Often the health staff would be notified to assess the condition of the child or children involved, which was sometimes problematic particularly where staff members were related (issues of confidentiality, and conflict of interest). The local Board members, portfolio councilors and health committees would be appraised of the situations by the local managers so that they would be kept informed of the organizational processes being taken, and provide the required support and advice; other cases included such things

<sup>110</sup> PBCN Health Services Inc., report for Options for Salary Grid Increases, October 1997, PBCN Health Services Inc., Prince Albert, Sask.: 1997; also from Board Minutes, Oct 1997, ibid.

<sup>111</sup> PBCN Health Services Inc., The Administration Manual, also called the General Procedures Manual 2000; Prince Albert, Sask.: 2000, page 36



as community complaints against staff performances, vandalism in the health residences and facilities; potentially sensitive medical treatment issues and reported deaths in the communities.

## 2. Internal Operational Reviews

The Board had several operational reviews, one with decentralization which led to the restructuring of management functions in October 1997, and a financial operations review in August 1998 where they hired an accounting firm to conduct a review of their existing financial systems and business cycles (expenditures and control options), to recommend controls (procedures, job descriptions, training) and to evaluate the implementation of these recommendations (audit, evaluation, client testing on expenditures) which led to internal financial control changes and hiring of additional staff.<sup>112</sup>

## 3. Participation in provincial and national working groups with FSIN, AFN, MSB or other external agencies.<sup>113</sup>

The Board policy was to encourage participation by management staff in these forums for information gathering reasons unless that commitment to external committees unduly affected their normal course of work in the organization. The Executive Director usually provided approval for the program managers. In 1998, for example, the Board agreed to participate in the formation of a third level health authority for the northern First Nation health agencies. The Northern Intertribal Health Authority (NITHA) was federally funded as a pilot demonstration project in

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<sup>112</sup> PBCN Health Services Inc., report by Deloitte & Touche, Report on The System of Financial Controls: PBCN Health Services Inc. Phase 1, October 1998, PBCN Health Services Inc., Prince Albert, Sask.: 1998

<sup>113</sup> PBCN Health Services Inc. Board Minutes, January, March 1998, PBCN Health Services Inc., Prince Albert, Sask.: 1998

third level health delivery and it involved PBCN, the Meadow Lake Tribal Council, Lac La Ronge Indian Band and the Prince Albert Grand Council. The Board of NITHA involved the Chiefs of these agencies with a technical advisory group consisting of the various senior managers. At a provincial level, the agency managers were also part of a Senior Technical Advisory Group (STAG) on health matters to the Federation of Saskatchewan Indian Nations.

#### 4. Local community protocols regarding funerals, treaty days

The general policy directive from the Board was to authorize the local managers to close the clinics for funerals, except for emergencies, as advised by the health committees and Chief and Council out of respect for the family of the deceased, but that the staff were expected to attend, unless they chose to work which often happened in the case of nurses during doctor days. For Treaty days, PBCN member staff was given that day off for attending the events.<sup>114</sup>

#### 5. Issues with Physician services.<sup>115</sup>

There were many ongoing community and staff complaints with respect to doctor services around timeliness, quality of care, hospital services and medical referrals since the Transfer in 1995. The Board was also faced with the problems around recruitment and retention of physician services. There were two types of payment schedules for doctors which could account for some of the issues with large volumes of clients being seen in the clinics and greater use of prescription drugs. The doctors from Northern Medical Services in La Ronge were paid by salary for their work in Southend, but the doctors from Flin Flon, who serviced both Deschambault

<sup>114</sup> PBCN Health Services Inc., The Personnel Manual, 2000, Prince Albert, Sask.: 2000, 47

<sup>115</sup> PBCN Health Services Inc., Board Minutes, January 1998, PBCN Health Services Inc., Prince Albert, Sask.: 1998

Lake and Pelican were paid on a fee-for-service system. The Board and management were of the view that salary-based physicians would deal with some of the workload and high prescription drug use issues.<sup>116</sup>

In 1999, the Board through the Northern Intertribal Health Authority requested an independent medical services review by Northern Medical Services, University of Saskatchewan in regards to the continuity and quality of physician services in their communities.<sup>117</sup> The review, which consisted of meetings, interviews, document searches and community visits, reported concerns with the inconsistent supply of physicians, lack of continuity of patient care between the communities and the Flin Flon General Hospital, physicians not being integrated into the community primary care group, poor utilization of the primary care nurses' acute care skills, high patient volumes, limited physician-patient interaction, and prescribing practice issues among others. These findings were consistent with the management reports to the Board where the nurses felt their skills were being underutilized in the acute care offered by the doctors and general concerns ranging from quality of care issues such as the prescribing practices by the doctors to the same clients to their perceived unprofessional behaviors and attitudes to patients and staff.<sup>118</sup>

The report provided the means for joint negotiations between the provincial health department, MSB, Northern Medical Services, Mamawetan Churchill Health

<sup>116</sup> PBCN Health Services Inc., 1998-1999 Annual Report, PBCN Health Services Inc., Prince Albert, Sask.: 1999., 9 under "nursing report."

<sup>117</sup> Butt Peter Dr., Director, Northern Medical Services, University of Saskatchewan, Draft of the PBCN Medical Services Review 1999, Northern Medical Services, Saskatoon, Sask.: March 24, 1999

<sup>118</sup> PBCN Health Services Inc., Board Minutes, February 1999, PBCN Health Services Inc., Prince Albert, Sask.: 1999; also PBCN Health Services Inc., 1999-2000 Annual Report, PBCN Health Services Inc., Prince Albert, Sask.: 2000., 11, under "nursing report."



Authority in La Ronge, and the Normand Health Authority in Flin Flon. The result was that a cost-sharing agreement was negotiated putting all fee-for-service physicians under salary.<sup>119</sup> The high volume of patients was anticipated to decrease to a more manageable average of 25 patients per day, as opposed to previous averages of patients seen per day in the communities, 53 to 70 in Pelican Narrows for 5 days and 31 in Deschambault at one day a week.<sup>120</sup> It was anticipated that while there would still be recruitment and retention issues due to the broader shortage of physicians across the country, the change to salaried structures would result in improved care and team building by enabling the nurses to hold parallel clinics, maximizing their clinical skills and improving job satisfaction, and working with the doctors by referring the more serious cases.

#### 6. Recruitment and Retention of Nursing and Community Support Personnel

The nursing director reports from 1995-1996 indicated an ongoing concern with sustainable staffing of appropriate medical personnel in the clinics, particularly in nursing.<sup>121</sup> The high nursing staff turnovers, especially in the first few years of operation, were attributed to such things as other job offers and heavy workloads,<sup>122</sup> and nursing shortages.<sup>123</sup> The cumulative impacts of these stresses were also attributed to the imbalances caused by having to deal with crisis situations and treatment

<sup>119</sup> Ibid. 1999-2000 Annual Report, 11 under "nursing report."

<sup>120</sup> Butt Peter Dr., Director, Northern Medical Services, University of Saskatchewan, Draft of the PBCN Medical Services Review 1999, Northern Medical Services, Saskatoon, Sask.: March 24, 1999, 11-13

<sup>121</sup> PBCN Health Services Inc., Director of Nursing Services Reports 1995-2000, PBCN Health Services Inc., Prince Albert, Sask.: 1995 to 2000. Also, in the PBCN Health Services Inc., Annual Reports 1995-2000, under "nursing annual reports." Also in Board Minutes, March 1998

<sup>122</sup> PBCN Health Services Inc., Director of Nursing Report, November 1995, ibid.

<sup>123</sup> PBCN Health Services Inc., Annual Report 1999-2000, PBCN Health Services Inc., Prince Albert, Sask.: 2000 under "director of nursing services message."

priorities rather than the more desired prevention and health education aspects of primary health care.<sup>124</sup>

The management response was to develop innovative methods for recruitment and retention through various financial incentives and benefit packages, organized salary grids, setting up an internal relief pool of nurses, pharmaceutical support services in the clinics, ongoing training opportunities and coordinated program supports with other health staff. Although nursing retention continued to be a challenge for the Board during the 5 year period, the nursing reports suggested a fairly stable workforce with nursing positions being filled with permanent, casual and relief staff.<sup>125</sup> The 1995-96 and 1999-2000 nursing reports, for example, indicated that Pelican Narrows was able to hire its full complement of 8 nurses in both periods, although clearly there was also much turnover with nurses staying for short term periods, between one and two years at best. Southend and Deschambault were comparable in size and more successful in terms of staffing their three to four nursing positions than the larger and busier community of Pelican Narrows which had to serve a population of over 3000 people through the efforts of 35 permanent staff, including 8 nurses and 10 relief staff. According to the 2003-2004 nursing report, all three communities maintained relatively stable nursing staff, although there were several vacant positions in Deschambault that were being filled with the PB Health relief nursing pool. In that year, Nurses in Pelican saw 3443 clients after hours, yet the community was still able to keep the same nursing coordinator there for over four

<sup>124</sup> PBCN Health Services Inc., Nursing Program Reports, Oct 1996, November 1997, PBCN Health Services Inc., Prince Albert, Sask.: 1997

<sup>125</sup> <sup>125</sup> PBCN Health Services Inc., Director of Nursing Services Reports 1995-2000, PBCN Health Services Inc., Prince Albert, Sask.: 1995 to 2000.

years. In comparison, Deschambault nurses saw 978 people after hours and Southend, 981.<sup>126</sup> Considering the workloads and the national nursing shortages, the support shown by the Board in terms of providing support staff and services, like security for night shifts, helped to retain the nursing staff as much as it did.

The development of an organized home care nursing program in 1996 with professional assessment and nursing components also provided additional support towards improving nursing services to the people with chronic medical and social issues such as the elders, and those with special needs.<sup>127</sup> The Home Care Program was unique in that elders were integrated as consultants in the design and development of the program which resulted among other things in a case management approach to patient care which involved individuals and families in the planning of their own care and providing medical and other support systems to help them in looking after themselves at home.<sup>128</sup>

The changes to the nursing program focus towards case management approaches were well described in the following scenario depicting patient care:

“ A client comes in to the clinic and fears he/she may have diabetes. What would be the new protocol?

- The nurse obtains the history, does all the lab work. Teaching is involved at this moment, re: What is diabetes? What are the signs and symptoms? What are the physical/physiological causes of diabetes? What tests need to be done? How do we determine if this is really diabetes?
- The nurse refers the client to the physician.

<sup>126</sup> PBCN Health Services Inc., Annual Report, 2003-2004, PBCN Health Services Inc., Prince Albert, Sask.; 2004, 21-23, nursing report

<sup>127</sup> PBCN Health Services Inc., Nursing Report August 1997, PBCN Health Services Inc., Prince Albert, Sask.; 1997 reporting on the change of nursing focus to follow-up procedures.

<sup>128</sup> PBCN Health Services Inc., Interim Report to Board of Directors on Home Care Needs Assessment and Program Proposal, January 1996, PBCN Health Services Inc., Prince Albert, Sask.: 1996; and in PBCN Health Services Inc., Annual Reports 1995 - 2000, under the “nursing annual reports in 1995 to 1997, and “director of home care” reports from 1998 to 2000



- Client sees the physician for possible admission to the hospital for further testing or for stabilization of diabetes. Intensive teaching is done at this stage with the client while admitted and following discharge.
- During the client's hospital stay, the CHD (community health developer) and CHN (Community Health Nurse) would meet with the family to discuss what diabetes is, what the signs and symptoms are, what to expect when the client comes home, nutrition, lifestyle changes, impact of a chronically ill family member in the home, coping mechanisms in place...etc.
- Once the client returns home, the CHD/CHN will work closely with the client and family to provide support and to assure that all their needs are met. Other disciplines could be brought in should there be problems with coping...for example: if the client suffers depression once he/she has been diagnosed, the Holistic workers could be called in to do person/family counseling.
- Last but not least, the CHD can plan community education to address the subject of diabetes. She could organize actual diabetic clients and families to discuss how this illness has affected them."<sup>129</sup>

The development of an internal core training program for many of the community health staff to upgrade their educational levels and help them move towards formal specialized education in their respective areas,<sup>130</sup> and the development of an education scholarship fund in 1995 for PBCN students going into health-related fields<sup>131</sup> were some of the other ways the Board tried to facilitate opportunities and build local capacity and sustainability in the communities. In a 1996 assessment of the community health staff in the various programs, it was found that while most had aspirations for higher education, many did not have grade 12 and could not take advantage of the programs offered by the universities and technical

<sup>129</sup> PBCN Health Services Inc., Nursing Report August 1997, PBCN Health Services Inc., Prince Albert, Sask.: 1997,

<sup>130</sup> PBCN Health Services Inc., Community Development Report, Oct 1996, July 1997, PBCN Health Services Inc., Prince Albert, Sask.: 1996, 1997, ; also Director of Holistic Health Report, August, 1996, February 1999, *ibid*.

<sup>131</sup> PBCN Health Services, Board Minutes, December, 1997, PBCN Health Services Inc., Prince Albert, Sask.: 1997

institutes.<sup>132</sup> The core training program had 35 health staff being trained in all the communities through accredited modules taught by the program managers and by 2000, out of the 35 original students registered, 23 completed their certificates for the first phase of the program<sup>133</sup> and were able to start the second or specialized phase which was designed to certify them in their various areas such as addiction counseling and home care.<sup>134</sup>

#### 7. Relations with Business Partnerships

The Board through the organization was involved in 2 business partnerships, one with an ambulance company in Prince Albert providing ambulance services to PN and Deschambault Lake region and with the PBCN Band on a pharmacy located in Prince Albert servicing the general public as well as the PBCN health clinics in the outlying communities.<sup>135</sup> The additional services to the communities included ambulance attendants located in Pelican Narrows and pharmacist visits on site in Pelican Narrows and Deschambault Lake. The Executive Director, as the representative in these ventures, was responsible for regular reports to the Board.

#### Chief & Council Relations

The Board relationships with the Chief and Council were much closer in terms of frequent contact than they were with MSB. The contacts with MSB officials were mostly limited to financial, program and regulatory matters and involved the managers of PB Health more than the Board. The general challenges that the Board

<sup>132</sup> PBCN Health Services Inc., Community Development Report, Oct 1996, *ibid*.

<sup>133</sup> PBCN Health Services Inc., Annual Report 2000, PBCN Health Services Inc., Prince Albert, Sask.: 2000 under "Director of Holistic Health's Message."

<sup>134</sup> PBCN Health Services Inc., Director of Holistic Health Report, Sept 2000, PBCN Health Services Inc., Prince Albert, Sask.: 2000; also, Director of Home and Community Care Report, Oct 2000, *ibid*.

<sup>135</sup> PBCN Health Services Inc., Board Minutes, October 1995, November 1998, PBCN Health Services Inc., Prince Albert, Sask.: 1995, 1998; also in Executive Director Reports 1995-2000

faced in its relations with Chief and Council had to do with sorting out their respective roles and functions,<sup>136</sup> particularly when the political culture of the communities was such that people were used to going directly to the Chief and Council for all their concerns, including matters of health. Many believed that the Chief and Council being the "authorized government and legal authority on reserve on overall community health matters"<sup>137</sup> still retained overall power to overrule decisions made by the Board. Officially, however, while the Chief and Council still had significant influence with the Board through the governance and reporting structure, they could not vote at the Board meetings neither could they veto Board decisions.

The political culture was also personalized, communal and competitive generally along family and kinship lines and it affected how the Board balanced its relations with the Chief and Council. As descendants of hunting and trapping societies or what Weber would have described as "older social structures" consisting mostly of family groupings led by patriarchs, the community people still had varying degrees of respect for their familial obligations especially when it came to voting for political leaders, and in that sense, traditional networks continued to be a strong influence in Band matters.<sup>138</sup> People living under the traditional systems tended to put a greater reliance on the reasoning (wisdom) and personal feelings of "sympathy,

<sup>136</sup> PBCN Health Services Inc., The Health Service Transfer Agreement, 1995, Prince Albert, Sask.: PBCN Health Services Inc., s.3, 4

<sup>137</sup> PBCN Health Services Inc., The PBCN Health Services General Procedures Manual, February 2000 September 1995; revised February 25, 2000, Prince Albert, Sask.: 2000, 3, no. GPM-003; Also, in the PBCN Health Services Inc., Directional Plan, 1995, 13

<sup>138</sup> See page 4, 5 of Chapter 3 here describing PBCN Traditional Governance history with information taken from PBCN's involvement with the 1976 Aski-Puko Study, the 1963 report on the Indians and Metis of Northern Saskatchewan, by Helen Buckley and J. Kew, John Hawley.



favor, grace and gratitude"<sup>139</sup> of the individual leaders to help them in time of need, and given that government aid in the 1950's came through government agents, the tendency to depend upon Chief and Council leaders to advocate on their behalf for government aid became accepted practice in the communities. The Board then had to find ways of working with the Chief and Council and maintain their autonomy as well.

The Board did this by trying to build as neutral an organization as possible committed to delivering apolitical services to all regardless of who was in political power. They mostly related to the Chief and Council through the Portfolio Councilors, and followed their corporate structure as Board members in making decisions on organization matters. For example, the Board developed policy guidelines around an organizational code of ethics prescribing respectful behaviors among the Board, staff and health committees, such as not engaging in public criticism of others, maintaining confidentiality and not engaging in political activities that could be interpreted as conflict of interest.<sup>140</sup> The Board believed that a neutral organization meant a neutral staff, but it became quickly apparent that neutrality was a continuing best effort rather than a fact. There were practical difficulties for community staff in separating work and personal relationships because everyone was interrelated and personally affected by decisions made in the health centers matters whether they were at home or at work. There were high expectations of them on both sides. Even the non-Band employees who did not have relatives in the communities

<sup>139</sup> See page 4 of Chapter 3 quoting Max Weber in 1946 book entitled Bureaucracy, by H.H. Gerth and C. Wright Mills

<sup>140</sup> PBCN Health Services Inc, The Personnel Manual, PBCN Health Services Inc., Prince Albert, Sask.: 2000, under "Code of Ethics," 3, 4,

experienced a sense of not being able to "leave the workplace," and feeling like they were "24 hour employees" without a "life of their own beyond the clinic."<sup>141</sup>

The idealized "arms length" administrative separation from Chief and Council was similarly challenged by practical considerations, such as having the Portfolio Councilors participate in Board policy-making through their ex-officio membership at all the Board meetings. Ideally, "arms length" implies some formal separation between politics and the administration of public services which some call the "politics-administration dichotomy."<sup>142</sup> It was based on an earlier idea that politicians would make decisions which would then be implemented by government bureaucrats, but this notion is no longer accepted as a valid description of real life today, and in the case of the Board, the idea that they could be completely separated from the political influence of the Chief and Council was not a realistic notion. As a governing entity, the Board, as policymakers, could not be completely neutral because they were engaging in an "inherently political and value-laden process"<sup>143</sup> by having to make choices between competing interests. Therefore, the reality was more of best-efforts neutrality.

The seeming contradiction between the idea of an independent Board and an organizational structure which continued to give the Chief and Council a great deal of power suggests the resiliency of some of the residual influences of past governance systems, particularly in small communities where Band government systems had been

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<sup>141</sup> PBCN Health Services Inc., PBCN Person To Person Summer Survey, August 1995, Prince Albert, Sask.: 1995, 14

<sup>142</sup> Nelson Marcia and Steve Patten. "Public Bureaucracy" in Brodie Janine, Sandra Rein, Eds., Critical Concepts: An Introduction to Politics: Third Edition, Toronto, Ontario: Pearson Prentice Hall, 2005, 149

<sup>143</sup> *ibid*, 149

entrenched for so many years within an environment of extensive kinship-oriented political networks. The creation of a governing authority autonomous from the Chief and Council was a new concept and there were some concerns by some Councilors that they would lose power and control over the health matters in their communities and not have a way of making the Board politically accountable to them. Consequently, limits were placed on Board authority by having the Chief and Council remain involved in health governance through reporting and approval conditions set out in the organization bylaws, such as retaining final authority to approve organization bylaws, Board annual reports and selections of local Board members and health committees and the participation of the Health Portfolio Councilors in the regular meetings and policy work of the Board.<sup>144</sup>

The other aspect of this seeming contradiction also showed the influence of the differing perceptions of "arms length" for both MSB and the Chief and Council. Arms length in the case of Board-Chief and Council relations refers more to financial separation rather than complete political separation. The Chief and Council still had the overall political authority over the Board, but the authority was more of a distributed authority. The Board was given broad administrative authority over the management of the organization and Chief and Council could not, by their own mandate, interfere in the decisions of the Board and the day-to-day running of the organization. While there was much concern with the political implications of having separate Boards, there was a larger concern about separating the finances of the health organization and the Band. The Band was facing serious financial problems at the

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<sup>144</sup> PBCN, *PBCN Community Health Care Plan, January 1995*, Pelican Narrows, Sask.: PBCN, 1995, 25-30



time of Transfer, and with the Band funding in jeopardy, MSB wanted assurance that health funds were being used for health reasons and not for dealing with the deficit problems and therefore, a separately administered health organization became the more favorable route. In essence, for MSB, "arms length" meant separate administrations as illustrated by a specific reference in the Transfer Agreement which made it clear that health program funding could not be transferred to "any other Band program or for other Band operations."<sup>145</sup>

While the Board's relations with MSB were more clearly attached to program and financial matters, their relations with Chief and Council spanned both political and operational matters. The Chief and Council through the Portfolio Councilors were ex-officio, non-voting participants in policy making at both levels of health governance, at the regional level through the Board meetings and at the community levels through the health committees.<sup>146</sup> The local meetings, in particular, were not limited to making program policies; they covered a broad spectrum of local problems to which the Board had no authority or resources. It was hard to distinguish what was "political" and what was "administrative" as far as the division of labor was concerned between the Portfolio Councilors and the Board.

Although the Board had the authority to manage health services according to their own policies and procedures, the practical reality was that they also needed the help of Chief and Council to deal with many of the community concerns and to develop appropriate health policies. The notion of "holistic health" upon which the

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<sup>145</sup> The Minister of National Health and Welfare, The Peter Ballantyne Band, The PBCN Health Services Inc., The Health Service Transfer Agreement, 1995, Prince Albert, Sask.: 1995, cl.17(1)

<sup>146</sup> PBCN Health Services Inc., The PBCN Health Services General Procedures Manual, February 2000, Prince Albert, Sask.: 2000, 3, no. GPM-003

vision of PB Health was based, practically covered all areas of community life and consequently, people expected the Board and health staff to deal with all kinds of local problems such as poor housing conditions, bad roads, requests for an airstrip, dog control, taxi contracts, security, drugs and alcohol issues,<sup>147</sup> all of which could arguably be "health-related" but not specific to the Transfer Agreement, and therefore, the responsibility of the Chief and Council. The Board usually referred community specific requests, like the airstrip, to the Executive Director to follow up at the community level, and to assist the Portfolio Councilors by way of information and data support such as the frequency of medical emergencies.<sup>148</sup> There were clearly areas that the Board obviously did not have the resources nor the authority to do things, like building airports for air medivacs for example, so their role was more of an informational source to the Chief and Council in their negotiations with the various levels of government.

The Board was faced with having to continuously update and educate the public about the role of the organization with respect to services that were not directly within the mandate of Health Services. This was done both formally through official channels and informally through general personal contacts. Formal education was done both internally with the health staff and health committees through orientations and a variety of in-service training forums and externally, with other primary authorities such as the Chief and Council and other local service agencies through formal meetings and through the course of their respective day-to-day working

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<sup>147</sup> PBCN Health Services, Board Meetings, April 1996, December 1997, February 1998, May, October 1999, April, September, 2000, Prince Albert, Sask.: 1995-2000

<sup>148</sup> PBCN Health Services Inc., Board Minutes, April 1996, PBCN Health Services Inc., Prince Albert, Sask.: 1996

relations.<sup>149</sup> Public education was usually in the form of community Chief and Council meetings where the managers on behalf of PB Health gave health reports. The Board and health committee members were not required to give formal reports at these meetings but were expected to support the managers whenever they could. Most of the questions tended to be personal and specific to running of the health centers. Accordingly, it was usually the managers who handled them.

In terms of day-to-day public education, there was an understanding reflected in most job descriptions<sup>150</sup> that people involved in the health process would promote the mission and objectives of PB Health and their roles during the course of their work with the public and if presented with specific problems, the Board policies with respect to lines of communication were provided.<sup>151</sup> Some methods used for public information and education were disseminated through informational pamphlets,<sup>152</sup> the PB Health Annual Reports, health reports to Chief and Council and in community meetings, Health Director reports to the Board, and community health center newsletters.<sup>153</sup> An example of some of the comprehensive type of information in monthly community newsletters was described in the newsletter done by the Deschambault Lake health center in December 1997. The theme of the month was

<sup>149</sup> PBCN Health Services Inc., Director of Community Development Reports 1995- 1996, PBCN Health Services Inc., Prince Albert, Sask.: 1995-96

<sup>150</sup> PBCN Health Services Inc., some examples of job descriptions in management, Executive Director, Director of Holistic Health, Community Development, health coordinators/directors, Business manager, and community staff - water quality technician, nursing, community health developers, holistic health developers

<sup>151</sup> PBCN Health Services Inc., The PBCN Health Services General Procedures Manual, February 2000, Prince Albert, Sask.: 2000, 2, no. GPM-002

<sup>152</sup> PBCN Health Services Inc., The PBCN Health Services Transfer: Working Together Towards Healthy Families and Communities, Prince Albert, Sask.: PBCN Health Services Inc., August 1995; pamphlet distributed at first staff orientation and subsequently at various other community meetings and health centers

<sup>153</sup> PBCN Health Services Inc., Health Director Reports November 1997-2000, PBCN Health Services Inc., Prince Albert, Sask.: 1997-2000; community newsletters attached to reports



"ski-doo safety." It described the clinic schedule, the various programs and activities such as the immunization, prenatal, school and chronic programs; a list of all the newborns and their parents; names of all the staff and their duties; plans for the upcoming months with themes such as "AIDS Education" and "FAS/FAE" and announcing events to coincide with national health themes such as the "national drug awareness week."<sup>154</sup>

The effectiveness of these various forms of public information was difficult to determine in terms of guiding community members towards more reasonable expectations about the kinds of services provided by PB Health. Although one of the more common assumptions in aboriginal governance is that governments or institutions with strong policy-making capacities will enable more public consultation,<sup>155</sup> build ties with communities to secure support, build commitment among their own staff,<sup>156</sup> the other side of the coin has to do with the fluidity of public expectations, and the question of whether even best efforts could ever succeed in meeting them. With limited information available concerning ways in which aboriginal organizations and governments involve their citizens in decision-making,<sup>157</sup> judgments regarding efficient or non-efficient citizen participation methods remain

<sup>154</sup> PBCN Health Services Inc., Jonah Sewap Memorial Nursing Station: Ski-Doo Safety, December 1997 Newsletter, Prince Albert, Sask.: PBCN Health Services Inc., Deschambault health center newsletter, 1997

<sup>155</sup> Institute on Governance, in collaboration with York University, CESO Aboriginal Services, Saskatchewan Federated Indian College, Understanding Governance in Strong Aboriginal Communities, Phase One: Principles and Best Practices, October 12, 1999, 16 (<http://www.iog.ca/publications/strong-ab-gov.pdf>)

<sup>156</sup> *ibid*, Understanding Governance in Strong Aboriginal Communities, Phase One: Principles and Best Practice, 35, quoting the World Bank, "World Development Report 1997"

<sup>157</sup> *ibid*, Understanding Governance in Strong Aboriginal Communities, Phase One: Principles and Best Practice, 48

highly questionable because there are no generally acceptable standards for measuring reasonable public satisfaction.

Some scholars suggest that community criticisms and dissatisfaction of Band governments and organizations will continue to exist even if "extraordinary"<sup>158</sup> measures were taken towards ensuring transparent hiring and decision-making policies and practices. They imply that the political culture in many aboriginal communities is generally divisive and suspicious of leadership with many perceiving that "corruption and nepotism" are common practices in Band governance,<sup>159</sup> and that most expressions of dissatisfaction arise from people feeling excluded from decision-making or "wronged in a variety of ways."<sup>160</sup> Most suggest that these divisions have been internalized over the years by people living under the Indian Act imposed systems of governance and related policies, such as the competitive Band elections every two years which pit families against each other as well as the divisions of power that follow between the 'have' and 'have not' groups.<sup>161</sup>

The extent to which these generalized observations can be applied to PB Health is uncertain, but the experiences of the Board suggest that a certain amount of political factions and family divisions did exist in the PB communities and may have accounted for the often unrealistic expectations that people sometimes had with

<sup>158</sup>Plumptre Tim & John Graham, Governance and Good Governance: International and Aboriginal Perspectives, Ottawa: Institute on Governance, December 3, 1999, 24, 25 quoting anthropologist Wayne Warry

<sup>159</sup> Institute on Governance, Governance Models To Achieve Higher Levels of Aggregation: Literature Review, Ottawa: Institute on Governance, September 2000, 7, taken from the RCOAP report, Vol.2, Part 2, 838

<sup>160</sup>Plumptre Tim & John Graham, Governance and Good Governance: International and Aboriginal Perspectives, Ottawa: Institute on Governance, December 3, 1999, 24, 25 quoting Wayne Warry

<sup>161</sup> Institute on Governance, Governance Models To Achieve Higher Levels of Aggregation: Literature Review, Ottawa: Institute on Governance, September 2000, 7, quoting the Royal Commission Report; Plumptre Tim & John Graham, Governance and Good Governance: International and Aboriginal Perspectives, Ottawa: Institute on Governance, December 3, 1999, 24, 25 quoting Wally McKay, Wayne Warry

respect to the Board, whom they saw, not as a separate entity, but as part of the Band administration. Therefore, if the requests to the Board for better and more housing (thus better health) were not responded to as quickly as people hoped, all the Band agencies got blamed for appearing somewhat ineffective and unresponsive. For example, the results of a survey done after 5 years of Transfer suggested that the Board and other agencies were not doing or working hard enough,<sup>162</sup> although 74.5% did say that medical services were adequate.<sup>163</sup>

The Board was aware that they could not satisfy everyone and they also understood that the familial and very personal nature of the community life influenced most people's personal perceptions about Health Services. The political culture was such that if people had friends and relatives involved in the health system in some way, they tended to be more favorable towards PB Health, and sometimes had higher expectations as well. This awareness was reflected in the Boards' "Five Year Workplan"<sup>164</sup> which stressed better community-based health initiatives and management, skilled human resources and enhanced communications with the communities and Chief and Council as key goals. In terms of results, a community survey done in the first year of Transfer, reported that community awareness of PB Health services was "very limited" but that it was increasing with the additional hiring of the community health workers who were seen to be able to "link the community and the clinic, teaching the community about the transfer and various new

<sup>162</sup> Northern Medical Services, PBCN Five Year Evaluation of Health Transfer, Saskatoon, Sask.: NMS, Department of Family Medicine, College of Medicine, University of Saskatchewan, 2002, 43

<sup>163</sup> *ibid*, 30

<sup>164</sup> PBCN Health Services Inc., Board Meeting Minutes, March 1996, Prince Albert, Sask.: PBCN Health Services Inc., 1996, where the Board approved the 1<sup>st</sup> year and 5 year Workplan



positions.”<sup>165</sup> On the other hand, the report also suggested a “level of over-awareness of Band control” where some people were unrealistically expecting to be able to “drop in with no appointments” for minor problems.<sup>166</sup> Similarly, in the Five Year Evaluation Report, the survey findings showed that while most communities were generally satisfied with the health services they were getting from PB Health, their specific complaints had to do with more personal and specific service quality issues, such as unreasonable waiting periods to see the nurses or doctors.<sup>167</sup>

The expectations of the health staff and managers were specified more clearly through formal organization policies and procedures. The intention of the Board was to provide some standards and organization for the staff to help guide them in their relations and interactions with the general public, particularly a public where the majority of the staff, Board and health committees were closely related. The policies were generally consistent with broader governing principles where accountability in institutions is considered more in terms of management practices that outline and identify key reporting relationships and organized communication and command structures.<sup>168</sup> The policy guidelines were particularly relevant since most community issues tended to cross into the jurisdictions of other service agencies and referrals were commonly made between agencies. For example, housing problems were

<sup>165</sup> PBCN Health Services Inc., Health Transfer Evaluation Plan: Appendix E- Person to Person Summer Survey, August 1996, Prince Albert, Sask.: 1996, 7

<sup>166</sup> PBCN Health Services Inc., Health Transfer Evaluation Plan: Appendix E- Person to Person Summer Survey, August 1996, Prince Albert, Sask.: 1996, 7

<sup>167</sup> Northern Medical Services, Peter Ballantyne Cree Nation: Five Year Evaluation of Health Transfer, Saskatoon, Saskatchewan: , NMS, Department of Family Medicine, College of Medicine, University of Saskatchewan, December 18, 2002, 30

<sup>168</sup> Institute on Governance, in collaboration with York University, CESO Aboriginal Services, Saskatchewan Federated Indian College, Understanding Governance in Strong Aboriginal Communities, Phase One: Principles and Best Practices, October 12, 1999, 26 (<http://www.iog.ca/publications/strong-ab-gov.pdf>)

prevalent in most communities and Board members and health staff were often requested by individuals to help them try to get new housing, especially when they were experiencing health-related respiratory problems caused by mold and wood smoke. However, getting new housing for people was not part of Health's mandate, but advocating for healthy living environments did form a component of the environmental health program. Most cases were followed up by assessments from the Environmental health officer who later developed a comprehensive report to the Board and Chief and Council regarding health problems associated with mold in the older houses. Reports such as these were largely the extent of Health's participation in housing, although there continued to be expectations from the people to have the health staff continue to lobby the Band administrations and their housing committees to fix the houses or try to build new ones.

Even after the Transfer, the political leaders continued to exert political influence over the Board through periodic Band directives in the form of Chief and Council motions and Band Council Resolutions. These were particularly prevalent in the early years and less so as the organization matured. Most were associated with larger governance issues such as funding and government policy negotiation meetings with senior government officials rather than the day-to-day operational or health center functions. For example, when the Board was preparing to negotiate for a renewal to the Health Transfer in 2000, a Band Council Resolution (BCR) directed the PBCN Health Executive Director and technical staff to include the addition of new reserve communities to their negotiations.<sup>169</sup> The Board subsequently added an

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<sup>169</sup> Peter Ballantyne Cree Nation, Band Council Resolution, 30-09-99, Pelican Narrows, Sask.: PBCN, 1999

addendum to the 2000 Transfer Agreement that was renewed from April 1, 2000 – March 31, 2003 that outlined a process to have a government-working group to develop possible funding options for these new reserves.<sup>170</sup> Unfortunately, the working group never materialized partly due to frequent changes in MSB personnel and the inability of both MSB and PB Health officials to find funding sources for the new reserves. Subsequently, when the Transfer was renewed again from 2003- 2008,<sup>171</sup> these funding issues had not been resolved, although a TLE policy had been created in Ottawa, and some interim regional funding provided for Kinoosao.

In following through with requests, such as seeking funding for the TLE reserves, the Board recognized the Chief and Council's authority over larger governance issues related to Treaty rights, as well as specific appointments related to Board and Health Committee selections and the determination of Board Bylaws. However, they also recognized that they, as a Board, had authority over issues that were specifically operational, such as setting Board meeting dates, and while the Board made all attempts to accommodate the various interests of the Chief and Council, if it proved inefficient for the organization, then the Board would follow their own decisions.

In 1998 for example, the Chief and Council passed unanimous motions directing all regional Board members to be selected by resumes and approved by the local Councils and that honorariums be paid to Board members who were Band staff and that they get their regular salaries deducted for the time away at Board meetings,

<sup>170</sup> PBCN Health Services Inc., The PBCN Health Service Transfer Agreement, 2000, Prince Albert, Sask.: PBCN Health Services Inc., 2000

<sup>171</sup> PBCN Health Services Inc., PBCN Health Services Inc., Annual Report 2003-2004: Executive Director's Report, Prince Albert, Sask.: PBCN Health Services Inc., 2004,



and that the Council did not approve of the Board holding Board meetings on weekends.<sup>172</sup> The Board followed through with the selection process requirements, but made their own decisions with respect to choosing times for Board meetings, or addressing issues of Board compensation for members who were Band staff. In the beginning, some of the members who were Band staff had difficulties attending Board meetings during the week, and while they understood the inconveniences of weekend meetings for Portfolio Councilors, the decision by the Board was to continue to schedule monthly meetings during the weekends.<sup>173</sup> In general, most of the issues involving operations were resolved at the Board level through procedural solutions. For example, with the issues involving Band staff attending weekday Board meetings and Council's concerns with weekend Board meetings, the Board later approved various financial compensations to the Band administrations for Board staff to attend weekday meetings which also resolved the concerns around weekend<sup>174</sup> meetings.

While these Band BCR directives were more of an exception than the rule, the less overt forms of political control were present through the degree of personal influence and networks and time that the Portfolio Councilors had with the Board, the health committees and the local health directors. Although the Portfolio Councilors could not vote on Board motions, they were able to fully participate in the discussions leading up to Board decisions and were able to exert their influence in that manner.

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<sup>172</sup> PBCN Health Services Inc., letter to the Board from the "Office of the Chief," PBCN Health Services Inc., Prince Albert, Sask.: March 10, 1998

<sup>173</sup> PBCN Health Services Inc., Board Minutes, February 1998 Teleconference, PBCN Health Services Inc., Prince Albert, Sask.: 1998

<sup>174</sup> Nelson Marcia and Steve Patten in Critical Concepts: An Introduction T Politics: Third Edition, Janine Brodie and Sandra Rein, eds., Toronto, Ontario: Pearson Prentice Hall, 2005, 149

Their influence on the daily management and operations of the organization depended upon their own workloads and upon their relationships with the Executive Director or local health directors and how often they were requested to resolve certain politically sensitive issues in the communities or to assist with negotiations and meetings with senior government officials on funding issues. While they were technically members of the health committees and thus involved in certain local operational matters such as being part of the hiring committees,<sup>175</sup> the levels to which they were involved in local health center issues were largely determined by their availability.

Generally, the Portfolio Councilors did not interfere with the Board and health staff unless people came to them with problems associated with the health centers, but they did expect to be kept informed of the major happenings in the health centers, particularly with sensitive issues like clinic hours, nursing services or the methods used to discipline local staff, since these had a tendency to spill over to community politics where people's perceptions of things were largely influenced from hearing and seeing rather than facts or processes. A good indication of this tendency was shown by the 5 year survey which noted the fluid nature of public opinion in small communities as reflected in the more negative perceptions of health staff such as, "there is no confidentiality – they are so nosy, they don't take time to check what is wrong with a person, they are too strict on weekends, they don't see patients on

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<sup>175</sup> PBCN Health Services Inc., The PBCN Health Services General Procedures Manual, February 2000, Prince Albert, Sask.: 2000, 4, no. GPM-003

weekends – they send them home,”<sup>176</sup> to the opposite views which commented that “they are doing a good job, it is all right at times.”<sup>177</sup>

The Board handled the community complaints brought up by the Chief and Council by referring them to a standard process required of everyone (including Chief & Council and Board members) to take all “concerns” or “complaints” through the appropriate lines of authority or chain of command set out in the organizational structure.<sup>178</sup> Technically, community complaints initiated at the local level were required to be written and given to the health director for further action. The common practice, however, was that most people continued to take verbal concerns to the Councilors and Board members who would then refer them to the appropriate channels. Concerted efforts were then made by the Board and managers to try to resolve them through the internal procedures of the organization.

For example, there was a case when some elders from the various communities went to their Councilors wanting the Home Care workers to chop wood for them like they did before Health Services took over the Home Care Program from the Band.<sup>179</sup> The Portfolio Councilors raised these concerns to the Board and wanted some resolution. The issue was that the new program had changed under health and the home care workers were no longer doing many of the daily household chores that they used to do when they were working for the Band. The Board in trying to resolve the matter had to review the matter with the managers and found that the new changes

<sup>176</sup> Northern Medical Services, PBCN Five Year Evaluation of Health Transfer, Saskatoon, Sask.: NMS, Department of Family Medicine, College of Medicine, University of Saskatchewan, 2002, 30

<sup>177</sup> *ibid.* 30

<sup>178</sup> PBCN Health Services Inc., The PBCN Health Services General Procedures Manual, February 2000, Prince Albert, Sask.: 2000, 1, no. GPM-003

<sup>179</sup> PBCN Health Services Inc., Board Meeting, January 1996, Prince Albert, Sask.: PBCN Health Services Inc., 1996



were necessary to improve nursing services to the elderly and yet, there was the practical expectation by the elders that certain chores, like chopping wood, should still be done for them.

Under the Band, the home care program had consisted mostly of untrained home care workers assisting the elderly on an informal basis with such chores as chopping wood. Nursing and case management were not part of the program. Many families and clients were depending upon homecare workers to do their chores for them rather than helping them until they were able to help themselves. According to the needs assessment which had been done by Health in their development of the program, the managers had found that the old program was making clients and their families too dependent on the home care workers to "do everything" for them rather than trying to "encourage independent living of the elderly" in their own home communities and having the families more involved in the care giving.<sup>180</sup>

Under Health, the program was organized around the definition and purpose of homecare which was to encourage independent living of people with chronic illnesses as well as the elderly in their home communities through case management – a system of assessing patients' needs, coordinating services and making appropriate referrals. New service standards of care were developed; new nursing staffs were hired in addition to the home care workers to provide such services as personal care assistance, respite care and professional assessments. Consequently, the home care workers were doing work more oriented to basic nursing such as feeding and nail care for their clients and less of the homemaking services that they used to do before. In

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<sup>180</sup> PBCN Health Services Inc., Interim Report to Board of Directors on Home Care Needs Assessment and Program Proposal, Board meeting January 1996, Prince Albert, Sask.: PBCN Health Services Inc. 1996

the end, the Board dealt with the issue by subsequently finding new funding sources to hire Elder workers in the communities to help the homecare staff with things such as elder nutrition Bingos, special feasts,<sup>181</sup> translation and advocacy services, transportation,<sup>182</sup> wood hauling, elders gatherings and visiting among other things.<sup>183</sup>

In a similar scenario, the Portfolio Councilors also raised the issue of adding youth components to health services through increased local activities and facilities for youth in the communities and to provide alternatives to alcohol and substance abuse. The Board subsequently approved new positions for youth workers in each of the communities. The youth workers were then able to organize and deliver health-related workshops and activities for the children and adolescents in the communities and they organized things such as cultural and sporting events, and youth festivals.<sup>184</sup>

While these cases had positive outcomes, there were many other needs that the Board could not meet and which continued to be raised at public forums such as the 2003 health conference which brought in elders, health committees, Chief and Council, Board members and staff for some strategic planning.<sup>185</sup> For example, two of the consistently common themes that were raised in the various workshops revolved around requests for renal dialysis equipment in the communities and improved services for diabetic patients, and more stable and better quality physician

<sup>181</sup> Jonah Sewap Memorial Nursing Station, Deschambault Lake Health Director's Report, November 2000, Deschambault Lake, Sask.: PBCN Health Services Inc., 2000

<sup>182</sup> Angelique Canada Health Center, Pelican Narrows Health Directors Report, November 2000, Pelican Narrows, Sask.: PBCN Health Services Inc., 2000

<sup>183</sup> Arthur Morin Memorial Health Center, Southend Health Directors Report, November 2000, Southend, Sask.: PBCN Health Services Inc., 2000; also July 2000

<sup>184</sup> Jonah Sewap Memorial Nursing Station, Deschambault Lake Health Director's Report, November 2000, Deschambault Lake, Sask.: PBCN Health Services Inc., 2000

<sup>185</sup> PBCN Health Services Inc., PBCN Health Services Conference: "Past, Present & Future: Celebrating Our Strengths-Confronting Our Challenges," January 28-30, 2003, Prince Albert, Sask.: PBCN Health Services Inc., 2003 – 3 sessions, 7 groups – had the same theme with respect to dialysis & doctors.

services in the communities. The issue with renal dialysis was that patients were getting tired of having to travel long distances by medical taxis to either Prince Albert or Saskatoon at least 2-3 times a week to access renal dialysis services.<sup>186</sup> Even as early as 1995, three patients were having to travel from Pelican Narrows to Saskatoon – a minimum 6 hr trip one way, 3 times a week. While the Board and managers tried to negotiate with the closest hospital in Flin Flon, Manitoba to provide these services, they could not do so because of unresolved jurisdictional matters between Manitoba and Saskatchewan and the lack of program policies and funding to deal with these problems by MSB. The main issue was not the cost of the machines to purchase, but rather that their maintenance and operations would be too expensive because of the requirements for qualified professionals and specialized facilities and in the case of PBCN, most patients needed care beyond the services that the health centers could safely provide.

On the other hand, the issues with the physician services in the communities had to do with ongoing public complaints about the unsatisfactory and inconsistent services associated with the physicians from Flin Flon, Manitoba which had been contracted first by MSB, then by PB Health to service the PBCN communities of Pelican Narrows, Deschambault and Sandy Bay.<sup>187</sup> Many of the public concerns with physician services that were raised prior to and after the transfer had to do with wanting physicians to have “more time taken, more thoroughness, more explanation and more sensitivity,” and many wanted to see “different doctors, other than those

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<sup>186</sup> PBCN Health Services Inc., Assistant Executive Director Report, November 1995, Prince Albert, Sask: PBCN Health Services Inc., 1995

<sup>187</sup> PBCN Health Services Inc., Board Minutes, April 1995, February 2001, Prince Albert, Sask.: PBCN Health Services Inc., 1995



from the Flin Flon Clinic serving the community.”<sup>188</sup> Historically, the practice had been for MSB and later PBCN Health, to contract with physicians based in Flin Flon, either through a private clinic or later through the regional health authority, to provide both telephone consultation and itinerant visiting services to these communities. But in spite of the efforts made by the Board and Chief and Council to work with the health authority in Flin Flon and actively seeking alternative physician services from Prince Albert,<sup>189</sup> they were not able to build a sustainable base of physician services because of difficulties associated with MSB funding formulas and policies and the national shortage of physicians. MSB funding was insufficient to attract physicians to northern communities and their policies regarding coverage for the costs for physician services and transportation were restricted to the nearest hospital sites, which was Flin Flon.

In trying to address the complexities around physician services, the Board commissioned several external reviews in 1996 and 1999 to review professional and physician services. Both reports described quality of care concerns associated with huge volumes of patients being seen by doctors during their “doctor days” in the communities, the lack of coordination and medical information flow between the hospital and the health centers, and the lack of integrated teamwork between the physicians and the other health professionals in the health centers.<sup>190</sup> For example, according to the 1999 report, in Pelican Narrows with a population of over 3000, the

<sup>188</sup> PBCN, Carter Jackie and Diane Martz, authors, Health Care Needs Assessment For The Members of The Peter Ballantyne Cree Nation Living At Deschambault Lake, Saskatchewan, July 1991, Prince Albert, Sask: PBCN, 19991, 116; also *ibid.*, for the Pelican Narrows assessment, 124

<sup>189</sup> PBCN Health Services Inc., Board Minutes, January 1996, Prince Albert, Sask.: PBCN Health Services Inc., 1996

<sup>190</sup> Kendel Dennis Dr., Dr. Dale Dewar, Professional Needs Assessment Project: Peter Ballantyne Cree Nation Health Services, 1996, Saskatoon, Sask.: College of Physicians and Surgeons of Saskatchewan, 1996

average number of people seen by physicians ranged from 53 to 70 patients per day.<sup>191</sup> These volumes created pressures and increased workloads for the nursing staff diverting them to doing lab work and filling prescriptions in the pharmacies rather than treating the patients, with the end result causing long waits for patients and limited time with them when they were seen.

The two reports were subsequently followed up with changes to the fee structure for the physicians from fee-for-service to salary, the addition of more doctor days in the communities, and improved integration in the health centers, such as Pelican Narrows, where nurses ran parallel clinics on doctor days which improved timeliness for seeing patients who were screened for the physician visits, and nurses seeing patients with physician backup unless the individuals wished to see the doctor.<sup>192</sup> These efforts to make changes to physician services appeared to be appreciated by the communities as demonstrated in the 2002 Transfer evaluation report with 74.5% indicating adequate medical services were being provided, but it was also clear that more had to be done to improve the quality of services, with comments like "sometimes it's hard to get service right away-you have to wait so long. I waited two hours in the waiting room and another half hour in the room so I just walked out and said never mind."<sup>193</sup>

As illustrated by the previous examples which described how the Board handled community requests raised by Chief and Council, it was evident that while

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<sup>191</sup> Butt Peter Dr., Peter Ballantyne Cree Nation Medical Services Review 1999, Saskatoon, Sask.: Northern Medical Services, University of Saskatchewan, March 24, 1999, 12

<sup>192</sup> Angelique Canada Health Center, Pelican Narrows Health Directors Report, November 2000, Pelican Narrows, Sask.: PBCN Health Services Inc., 2000; also August 2000 report

<sup>193</sup> Northern Medical Services Peter Ballantyne Cree Nation: Five Year Evaluation of Health Transfer, December 2002, Saskatoon, Sask.: Northern Medical Services, Department of Family Medicine, College of Medicine, University of Saskatchewan, 30

the Chief and Council had the authority and influence to decide larger policy questions, the Board had the authority to make policy decisions regarding the day-to-day operations of the organization and methods of program delivery and in areas not specifically raised or identified by Chief and Council. Although, the political culture of the communities was for individuals to take their complaints directly to the top, that is the Chief and Council, rather than going through the middle managers of the various programs (unless of course, they were closely related or were friends), the Chief and Council and Board members became more sensitive to setting an example and channeling community complaints through formal procedures and policies which they helped develop and approve.

The handling of community complaints by the Board and managers sometimes required more time than expected and sometimes the way the issues were handled generated some political micromanagement situations where it was difficult to differentiate between which actions were politically appropriate according to the policy guidelines of the organization and which ones were not. The terms "political micromanagement" is used in a generalized way here to help describe some of the situations where the Chief and Council would sometimes get involved in administrative matters such as staff discipline, thus making the resulting decisions appear political. This was not unusual. In fact, this tendency was noted in much of the literature on aboriginal administration as being a potential problem thereby suggesting a need to develop acceptable balances of power between the political and administration areas of aboriginal government.<sup>194</sup> Most scholars acknowledge that the

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<sup>194</sup> Plumptre Tim, John Graham, *Governance and Good Governance: International and Aboriginal Perspectives*, December 3, 1999, Ottawa, Ontario: Institute on Governance, 1999; Stephen Cornell,



balancing will be difficult for aboriginal governments because of the personalized nature of reserve politics where decisions are often influenced by power divisions along "kinship,"<sup>195</sup> "class and education"<sup>196</sup> lines.

For example, C.E.S. Franks predicted that the relationship between "politicians and administrators will likely be difficult to sort out. In the small self-governing units, where there are few positions on the administration side, power is likely to be 'fused' with elected leaders making many of the decision which in larger units are made by civil servants."<sup>197</sup> This was also the case in Canadian politics in the late 19<sup>th</sup> century. Political science scholars Nelson and Patten referred to the "extensive political manipulation," or "excessive patronage"<sup>198</sup> that was being practiced at a time when government departments were small and the civil servants more subject to the personal whims of federal politicians. On a broader note, the dictionary defines "politics" in a similar sense as "maneuvering for power within a group."<sup>199</sup>

For PBCN Health, what was considered "politics" was inferred in the behavioral guidelines listed in the Personnel Code of Ethics which all staff and health committee members were required to sign as an indication of their consent to the

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Joseph P. Kalt, Reloading the Dice: Improving the Chances for Economic Development on American Indian Reservations, Boston: Harvard project on American Indian Development, John F. Kennedy School of Government, Harvard University, March 1992; David A. Lynes, Cultural Spirit and the Ethic of Bureaucracy: The Paradox of Cultural Administration, Canadian Journal of Native Studies, Vol.15.1, 1995, 75-78

<sup>195</sup> Warry Wayne, Unfinished Dreams: Community Healing and The Reality of Self-Government, Toronto, Ontario: University of Toronto Press Inc., 198, 53

<sup>196</sup> Boldt Menno, Surviving as Indians: The Challenge of Self-Government, Toronto, Ontario: University of Toronto Press, 1993, 124

<sup>197</sup> Franks, C.E.S., Public Administration Questions Relating to Aboriginal Self-Government, Kingston, Ontario: Institute of Intergovernmental Relations, 1987, 57

<sup>198</sup> Nelson Marcia and Steve Patten in Critical Concepts: An Introduction T Politics: Third Edition, Janine Brodie and Sandra Rein, eds., Toronto, Ontario: Pearson Prentice Hall, 2005, 149

<sup>199</sup> Hawkins Joyce M., compiled The Oxford Dictionary with Canadian Appendix, Toronto, Canada: Oxford University Press, by 'Round the World Books Inc.

general conduct required of them by the Board. Among the many requirements for prompt and respectful behaviors on the job, the references to using "information obtained on the job for the intended purpose, not for his/her own interest or those of other persons," and treating "all people with respect and consideration at all times," suggested that everyone involved had to conduct their duties as objectively as possible.<sup>200</sup> While the same specific guidelines were not formally required for the Board and Chief and Council, it was inferred through the encompassing standard of care required by directors of corporations to "act honestly and in good faith," and to "exercise the care, diligence and skill" required of a reasonably prudent person in comparable circumstances.<sup>201</sup> But, this gray area was never formally clarified either by the Chief and Council nor Board policy, and was left to be dealt with on a situational basis which led to a practice of informal accountability protocols with the Chief and Council. For example, in the case of Band-wide office closures due to statutory and special Band holidays, the informal Board protocol was to wait for the Chief's directive before approving clinic closures through Board motion and directing managers to give notices to the health employees.<sup>202</sup> The Board had the authority not to follow the Band directives with respect to Band-wide office closures, but they did not do so because of the inconsistencies it could generate between Band-related programs and the potential hard feelings it would cause with health staff in the communities.

<sup>200</sup> PBCN Health Services Inc., PBCN Health Services Inc., The Personnel Manual, 2000, Prince Albert, Sask.: PBCN Health Services Inc., 3, 4

<sup>201</sup> PBCN Health Services Inc., Board of Directors Orientation, September 13, 2000, Prince Albert, Sask.: PBCN Health Services Inc., 2000

<sup>202</sup> PBCN Health Services Inc., memorandum from Office of Chief, Dec. 1997, PBCN Health Services Inc., Prince Albert, Sask.: 1997; followed by PBCN Health Services Inc., Board Motion, December 1997, PBCN Health Services Inc., Prince Albert, Sask.: 1997, which gave approval to follow Band directive.

The other more common situations, which drew in Chief and Council involvement, involved personnel issues, particularly those involving the disciplining of Band-member employees. In these matters, the Board had to balance its decisions between applying the provisions of the Personnel policy or going the political route.<sup>203</sup> Generally the Portfolio Councilors would receive complaints by staff if they were unhappy with the way certain managers were carrying out their disciplinary processes and the Councilors would report these to the Executive Director and raise them at the Board meetings. The Board in considering the issues had to weigh external factors such as political motivation and personal relationships, particularly if Chief and Council elections were imminent which tended to create a more intensified political environment of community complaints and political demands for action. Questions would arise as to whether it was in the best interest of the Portfolio Councilor(s) to get involved in personnel issues when elections were fast approaching and when it was the mandate of the Board to oversee these kinds of health service issues. On the other hand, raising issues was part of the role of the Portfolio Councilors in their authority to monitor the overall programs of health services for the communities that they represented. They would raise issues when they felt that the operations of a certain community were not working right and where particular staff felt and believed that they had no one to turn to after failing to resolve their issues through the formal avenues of management, local board member(s) and health committees. The Board's position in these matters was consistent in that while they acknowledged the concerns and roles of the Portfolio Councilors and that they needed

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<sup>203</sup> PBCN Health Services Inc., Board Minutes, February 1996, PBCN Health Services Inc., Prince Albert, Sask.: 1996



to work more closely with them, they had developed policies to deal with personnel issues for the management and supervisors to follow, and were thus obligated to abide accordingly.

In resolving politicized personnel issues, the Board would request the Executive Director and appropriate manager to review the facts of the situation, the steps taken in the disciplinary process (ie. verbal, documentation) and the nature of the complaints by the staff. Most of the personnel issues were usually grounded in actions resulting from problems associated with personal pressures, such as family problems or addictions, to work-related pressures such as not getting along with supervisors and being unhappy with their job situations. The Board was consistent in communicating their decisions to the staff through the managers, although there were several instances in the first few years of the Transfer when an affected employee came to present their case to the Board directly, rather than through the management channels. Both the manager and staff person were given the opportunity to present their side and the board weighed these in relation to their decision to implement the disciplinary policy. It was the position of the Board that staff understood the working protocols and while they may have had justifiable concerns, they could not bypass management and go to a political route to get their matter settled.

In terms of communicating their decisions, the Board would also provide internal recommendations to management such as improving the communication and trust within the clinic through an emphasis on teamwork, and developing better communication systems with the general public so that they were aware of proper protocol in dealing with health personnel matters through the organization rather than

through the political leadership. The Chief and Council and the Board preferred to deal with local issues at a local level and not at a regional Board or full Council level. Therefore, the decisions and actions of the Board would then be communicated through the appropriate channels. If the matters were considered to affect all communities, the Chief would request that a report be made at a regional Council meeting, but if they were more of a local matter, the report would be made at the affected community's Chief and Council meeting.

In terms of Chief and Portfolio Council attendance at Board meetings, the Chief was not expected to attend all the Board meetings, unlike the Portfolio Councilors, and in practice, the Chief generally attended only when specifically requested or when serious matters needed to be resolved at the Council level involving matters of the health organization, employees or Board. For example, when the Board was trying to get more clarity with respect to the role of the Band in health governance, the Chief attended the Board meeting to discuss and explain band governance and how it related to the health Board under the Transfer Agreement.<sup>204</sup> It was understood that while the Board and organization had administrative and governing autonomy over the management and delivery of health services to the Band communities, the Chief and Council had the overall political authority to deal with the federal government, MSB, on matters of health. Accordingly, the Chief and Council requested to be kept informed and aware of the administrative procedures and actions of the Board and organization with respect to its dealings with MSB and other

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<sup>204</sup> PBCN Health Services Inc., Board Minutes, February, April, 1996, PBCN Health Services Inc., Prince Albert, Sask.: 1996

political affiliates, and to be consulted as needed by the Board and management on operational and community issues.

The Chief and Council tended to become more involved in community-personnel situations when they were not fully informed about what the organization was doing in dealing with these issues, or when they were starting to face political pressures from band members as a result of perceived wrongdoings by any of the employees, Board, or health committees. In these instances, the Executive Director and appropriate manager(s) would be requested by the Board to report on these matters to the Chief and Council at their meetings. In the regular course of business, the Portfolio Councilors were the link to the Chief and Council and because of their regular contact and awareness of matters with the health clinics were more prone to becoming involved in matters over and above their advisory roles.

In the first few years, the Chief and Council - Board roles and functions were

questioned more frequently by some Councilors, although there was majority political support overall for the Board's decisions as long as they were kept informed and consulted about situations which could have political implications for the whole Band. Some of the fears were that the Board would get too independent of the Chief and Council and not have to be administratively and politically accountable to them in the way they managed health services. In a sense, these concerns over shared powers and accountability were similar to those expressed in the broader governance debate where state capacity scholars suggested that the power and influence of the state was "withering away" because of the devolution of too much governing and



administrative authority over public services to various regional boards and non-profit organizations.<sup>205</sup> The other side of the debate by scholars, who preferred a societal or a blended approach, suggested that the devolution of power and authority to Boards and committees in public affairs amounted to good governance and complemented, rather than diminished the political authority of the state.<sup>206</sup> Notwithstanding the concerns over Board accountability, the views of the majority of the Chief and Council with respect to their own internal Band devolutions were more reflective of the blended approach that promoted a working together of both political and administrative authorities. The Chief and Board Chairperson's remarks in 1995 to 2000 demonstrated this consistent theme to "work together" as a Chief and Council, Board and staff of the health organization for the betterment of health services in the communities.<sup>207</sup>

As previously mentioned, the PBCN political culture did not make it easier to clarify the roles between the Chief and Council and the Board either. The general public viewed the Chief and Council as having final political authority and accountability over all Band matters regardless of whether some of these were delegated to autonomous Boards, and therefore could intervene in situations when they disagreed with Board and management decisions.<sup>208</sup> The Board and staff had to balance the community expectations associated with ownership and Band control over health services with the organization's needs to coordinate a delivery system

<sup>205</sup> See Chapter 2, Theda Skocpol and Kenneth Finegold (2-4); Judith E. Gruber (14-15)

<sup>206</sup> See Chapter 2, Tim Plumptre, John Graham, David Hayne, Miriam Wood, Frank Cassidy and Robert L. Bish, John Pierre, Mark Turner and others (4-5).

<sup>207</sup> PBCN Health Services Inc., *Annual Reports, 1995 - 1996*, PBCN Health Services Inc., Prince Albert, Sask.: under "Chiefs message" and "Chairperson's message."

<sup>208</sup> PBCN Health Services Inc., *Health Transfer Evaluation, August 1996*, PBCN Health Services Inc., Prince Albert.: 1996, 7

through policies and procedures. An internal evaluation reported in 1996 reported that while people liked the positive changes with Transfer, some work still needed to be done in terms of quality of service. The community members wanted to feel more welcome in the clinics without the staff "getting mad" at them. There were also feelings among the staff that there was a level of "over-awareness" of band control in clinic matters leading to some perceived abuse of the health system where it was difficult to implement procedures and policies. One example described some people dropping in without appointments during doctor days. The practice in all the clinics was to schedule appointments with the doctors who were only available to see patients during their weekly visits to the communities.

It was understood that the Chief and Council were elected to serve the interests of the people and accordingly were perceived to have a more direct level of political accountability to the public as opposed to the more administrative accountability of the Board. The inference was that the Chief and Council had a duty to be more personally responsive to the needs of the Band members, rather than being more concerned about the needs and rules of the organization which some felt the Board was doing.<sup>209</sup> An internal evaluation report in 1996 acknowledged that while the internal controls prescribed in Board policies were positive in terms of increasing efficiency and bringing more organization and stability to clinic operations, the general feelings of the community and staff recommended a more flexible approach to implementing change with comments such as, "The Band has taken independence,

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<sup>209</sup> PBCN Health Services Inc., Board Minutes, January 1998, PBCN Health Services Inc., Prince Albert, Sask.: 1998

but they are taking things too fast. Don't worry about money, worry about health. Before worrying about business, get the clinics running effectively."<sup>210</sup>

In summarizing Chief and Council relations with the Board, the lack of specific communication protocols and formal terms of reference between them remained unresolved and left to be dealt with on a situational basis. The Board Bylaws provided general references to the role of Chief and Council as "trustees" for the membership of the PBCN Health organization and the role of the Board of Directors as the governors of the organization.<sup>211</sup> The administration policy manual, which set out the operational procedures of the organization, also kept the references to the policy roles and functions of the Chief and Council, the elder and Board within broad descriptions.<sup>212</sup> These referred to the delegated authority given by Chief and Council to the Board over the administration of the Health Transfer Agreement, and the responsibility of the <sup>213</sup>Portfolio Councilors to oversee the general administration and coordination of health services. What this meant, however, was left unclear. The duties of each were not specified in detail probably because it was awkward for the Board members to create and enforce rules for their political superiors whom they depended upon for their appointments. It was also not a big issue for the people. They were not overly concerned about separating policy-making and administration, or separating the roles of Chief and Council and the Board. They were mostly concerned about getting their medical and health needs met in a timely way.

<sup>210</sup> PBCN Health Services Inc., Health Transfer Evaluation, August 1996, PBCN Health Services Inc., Prince Albert.: 1996, 11

<sup>211</sup> PBCN Health Services Inc., PBCN Health Services Bylaws, 1995, Prince Albert Sask.: PBCN Health Services Inc., 1995

<sup>212</sup> PBCN Health Services Inc., General Procedures Manual, February 2000, Prince Albert, Sask.: 2000, 3

<sup>213</sup> PBCN Health Services Inc., PBCN Health Services Conference, January 28-30, 2003, Prince Albert, Sask.: PBCN Health Services Inc., 2003



### MSB Relations

The Board relations with MSB were primarily through the day-to-day program administration channels between the organization staff and MSB staff, and through the more formal venues such as meetings between the senior officials and political representatives of MSB and the Board and Chief and Council regarding matters related to the Transfer Agreement. The general practice of moving an issue from a administrative realm to a political realm was not formalized in Board policy although the protocol with the Chief and Council was for them to be involved in meetings where larger policy issues were being discussed with senior MSB officials, such the Regional Director, the Assistant Deputy and/or Deputy Minister and the Minister of Health.

Most of these larger MSB issues had to do with policy gaps in the Indian Health Transfer Policy and the administrative and financial difficulties associated with implementing MSB national policies and standards attached to program funding arrangements. One of the more visible policy gaps that the Board experienced with the federal Transfer Policy involved the lack of provisions for funding the health services in new reserves created under the Indian Affairs Treaty Land Entitlement process.<sup>214</sup> Within the first PBCN Transfer period, 1995-2000, several new reserves had been created through the TLE process but were not funded. When the Chief and Council and the Board renewed their Health Transfer Agreement (2000-2003), they negotiated for an addendum to be attached to the Agreement outlining a process for negotiating the more serious outstanding policy gaps and program issues in the

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<sup>214</sup> PBCN Health Services Inc., Health Transfer Agreement Renewal, PBCN Health Services Inc., Prince Albert, Sask.: March 31, 2000, briefing notes for a meeting with the Assistant Deputy Minister of Health

Transfer such as funding issues relating to new reserves, population growth factors for on and off reserve populations, price and volume impacts of demographic and inflationary trends and the various program criteria and funding formulas for multi-communities such as the PBCN.<sup>215</sup>

At a follow-up meeting with the Minister of Health in 2001, the Chief and Council and Board expressed their concerns that after two years, the addendum issues still had not been addressed and Band members had been going without proper health services, although at a regional level, some interim operational funding had been provided for the fly-in community of Kinoosao, but the other communities still were not being provided funding on reserve and were having to access provincial services off reserve.<sup>216</sup> While MSB Ottawa had a draft TLE policy which identified PBCN, the official direction did not commit to any new funding and the MSB regional office was directed to find funds in their existing funding envelope which they advised the Board they did not have.<sup>217</sup>

The standardization of federal Indian Health policies across the country created the enforcement of rules and administrative procedures, which were mostly directed towards cost-saving measures and tighter financial accounting requirements and reporting methods. The Board had many administrative problems trying to implement the medical transportation and other programs under the Non-Insured Health Benefits program (NIHB) because of the financial limitations of the program

<sup>215</sup> PBCN Health Services Inc., PBCN Health Service Transfer Agreement: Addendum, 2000, PBCN Health Services Inc., Prince Albert, Sask.: April 1, 2000

<sup>216</sup> PBCN Health Services Inc., Briefing Note Presented to the Honorable Allan Rock, Minister Responsible For First Nations and Inuit Health Branch, August 3, 2001, PBCN Health Services Inc., Prince Albert, Sask.: 2001 under "background."

<sup>217</sup> PBCN Health Services Inc., Executive Director Report, August 2000, PBCN Health Services Inc., Prince Albert, Sask.: 2000

and the fact that approvals for things like medical transportation coverage were being coordinated by the MSB regional office in Regina, with some support from the MSB staff in the Prince Albert north zone office. The NIHB program is a national health benefit program, which pays for some or all of the costs associated with the medical, dental and pharmacy needs of First Nations and Inuit people. Most First Nations people interpret these benefits as part of their Treaty Right to health, and any restrictions are seen as capping Treaty rights.<sup>218</sup> It covers prescription drugs listed on the NIHB Drug Benefit List and for general "over-the-counter" medicines, medical transportation (travel to the nearest clinic or hospital), dental, medical supplies and equipment, vision and crisis intervention counseling.<sup>219</sup>

The impact of these policies at the community levels were experienced in the daily interactions between the local health staff implementing the MSB policies and individuals wanting certain services in the communities. Local managers and staff working in program areas such as nursing, transportation, addiction and treatment services were particularly prone to political stresses arising from having to deny certain requests. The Board and especially the local health staff were often caught between meeting community needs and following NIHB policies and felt frustrated because they had limited influence in changing the administrative and policy decisions made by the MSB regional and Ottawa offices.<sup>220</sup> These views were common to other transferred Bands as well who felt that the pressure was now on

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<sup>218</sup> Health Canada, Medical Services Branch, Long-Term Evaluation of Transfer: Final Report, October 1995, Ottawa: Institute for Human Resources Canada, 1995, 48

<sup>219</sup> Minister of Health Canada, Non-Insured Health Benefits Program: Information Booklet, Health Canada, Ottawa: 2003, 3-4

<sup>220</sup> PBCN Health Services Inc., Board Minutes February 1999, PBCN Health Services Inc., Prince Albert, Sask.: 1999,



local Band health administrations to interpret MSB policies and regulations, without having input into the MSB decision-making processes.<sup>221</sup>

The perception of the Board was that they had a duty, as expressed in the words of the PBCN Health elder, "to continue to remind our partners in the Treaty that these sacred documents were meant to be the foundation of our relationship with Canadians and they must be honored,"<sup>222</sup> and they felt that MSB had a treaty obligation to provide appropriate NIHB benefits. The NIHB benefits cover both on and off reserve band members, but the Health Transfer only covered the on-reserve health services through the clinics located in four of the PBCN communities identified in the Agreement. While First Nations considered Treaty Rights portable on and off reserve, the Board could not accommodate the numerous requests for health services by off-reserve Band members, although some provincial funding was accessed to hire a family services coordinator to develop and implement a family and child services program in Prince Albert. The program was designed to help PBCN families with medical and other-related issues such as language interpretation and advocacy with the other service agencies in the city and for developing special projects for underprivileged children, such as organizing children's events for Treaty Days, Thanksgiving and Christmas, and holding annual summer camps.<sup>223</sup>

In the case of pharmacy supplies and prescriptions, all prescription drugs were and continued to be subject to NIHB approval processes and while most were covered

<sup>221</sup> Health Canada, Medical Services Branch, Long-Term Evaluation of Transfer: Final Report, October 1995, Ottawa: Institute for Human Resources Canada, 1995, 48-49

<sup>222</sup> PBCN Health Services Inc., Annual Reports, 1999-2000, PBCN Health Services Inc., Prince Albert, Sask.: under "elders message."

<sup>223</sup> PBCN Health Services Inc., Annual Reports, 1995 to 2000, PBCN Health Services Inc., Prince Albert, Sask.: 1995 to 2000 under "Family Services Report."

under the approved over-the-counter medication, many required prior approvals, especially for new or specialized drugs and vitamins such as Slow K, Losec, and Calcium. Concerns with the slowness of the NIHB approval procedures were reflected in the PBCN Nursing manual which noted that the extensive steps needed to get approval for prescription drugs frequently interfered with the delivery of medication from the pharmacy to the health clinics.<sup>224</sup>

These NIHB drug approval processes had complicated requirements—physician prescriptions had to be faxed by the clinics to the pharmacy in Prince Albert, pharmacists started the prior approval process by contacting NIHB, the clinics were given a case number to start a file for a particular patient and their prescribed drugs, a questionnaire was faxed to the physician to be completed and faxed back to NIHB, not the pharmacy and if the questionnaire was not done by the physicians or by the nurses in the health clinics, within 14 days, the approval was cancelled and the process started all over again, - then following these steps, the NIHB office informed the pharmacy as to whether the drug was approved or not.<sup>225</sup>

The NIHB Transportation policies were another example. While the health clinics had transportation clerks for coordinating and implementing the transportation rules, the medical transportation program was administered by the MSB regional office in Regina and the clerks were required to get approvals for all transportation warrants. The transportation program was designed for transporting patients from the clinics to the nearest hospitals and covering their expenses for travel, either through a personal vehicle or taxi, their accommodations and meals. Throughout the whole

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<sup>224</sup> PBCN Health Services, *Nursing Manual, 2000*, PBCN Health Services Inc., Prince Albert, Sask.: 2000. 54-55 under "Ordering-Pharmacy Supplies."

<sup>225</sup> *Ibid*, 54-55

transfer period, the conditions, rules and payments attached to these benefits were a constant source of community complaints to the Board and Chief and Council.<sup>226</sup> In February 1996, for example, MSB officials met with health managers and taxi operators from several communities in Deschambault Lake to discuss things such as MSB's cut on the waiting time for taxis, the fixed \$1.05 mileage rate, and the slowness of payments that were being processed through Winnipeg. While the MSB officials were understanding of the issues, no changes were made by MSB and the situations remained the same right up to 2000.<sup>227</sup>

The Board's relationship with the MSB zone office on transportation issues was an advisory one. They provided recommendations with respect to choosing or denying local taxi operators for medical transportation business,<sup>228</sup> or advocating for approvals for individuals with special needs, but beyond that, MSB policies prevailed. Not everything was covered and what was covered did not keep up with inflationary factors which generated financial difficulties for many patients, and outside of local fund raising initiatives, appeals for assistance from the Band's social development program, some innovative local meal subsidy pilot programs such as the one in Pelican Narrows, individuals either had to either pay for services themselves or go without.<sup>229</sup>

In terms of the local medical transportation business, the Board had to balance the interests of both the local taxi operators and the patients using the services. The

<sup>226</sup> PBCN Health Services Inc., Board Minutes, PBCN Health Services Inc., Prince Albert, Sask.: April, July 1996; August, December 1997; January, February, May, July, 1998;

<sup>227</sup> PBCN Health Services Inc., Director of Community Development Report, February to March 1996, PBCN Health Services Inc., Prince Albert, Sask.: 1996, 1

<sup>228</sup> PBCN Health Services Inc., Board Minutes, PBCN Health Services Inc., Prince Albert, Sask.: July 1997

<sup>229</sup> *ibid*, May, August 1997, request for a similar meal subsidy program from another community



community interests ranged from patient safety concerns such as safe drivers, maintenance of the taxis, to quality issues such as consistency and reliability of service. On the other hand, local taxi operators found it difficult to operate their businesses under the fixed rates paid by MSB because they were not adjusted to meet inflationary factors such as the fluctuating and higher gas prices in the north, maintenance issues, and the lack of compensation for waiting time and accommodations on overnight trips to Saskatoon or Prince Albert.<sup>230</sup> The practice of the Board in balancing the business and service interests of the communities was to deal with them on a situational basis through the appropriate health managers and while they could not change the MSB policies, the Board was able to provide certain supports such as facilitating more timely financial arrangements with MSB and the taxi operators.

On the MSB side, escalating demands and expenditures upon regional NIHB budgets enforced tighter financial control policies rather than dealing with people's changing needs.<sup>231</sup> In 1991, a PBCN transportation needs assessment report indicated that over 99% of the medical transportation in Pelican Narrows was through taxis with 68% of the people being transported to the nearest hospital site in Flin Flon Manitoba, and the rest to Saskatoon.<sup>232</sup> In Deschambault Lake, 98% of the medical transportation was by taxi with 89% being transported to Flin Flon and the rest to

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<sup>230</sup> PBCN Health Services Inc., Director of Community Development Report, February to March 1996, PBCN Health Services Inc., Prince Albert, Sask.: 1996

<sup>231</sup> PBCN Health Services Inc., Board Minutes, PBCN Health Services Inc., Prince Albert, Sask.: August 1997

<sup>232</sup> PBCN, Health Care Needs Assessment For the Members of The Peter Ballantyne Cree Nation Living At Pelican Narrows, Saskatchewan, July 1991, PBCN, Pelican Narrows, Sask.: 1991, 25, report by Jackie Carter and Diane Martz under "medical transportation."

either Prince Albert or Saskatoon,<sup>233</sup> and in Southend, 88% was by taxi with 54% being transported to La Ronge and the rest to Prince Albert and Saskatoon.<sup>234</sup>

According to reported 1998 estimates of medical transportation costs, PBCN expenditures accounted for \$892, 714 out of a total of \$5.9 million spent in the north with almost 45% spent on taxis and the rest by private mileage, bus, ambulance and air travel.<sup>235</sup> The push-pull nature of MSB-Board relations throughout the first 5 years of Health Transfer was at times an uneasy alliance because of the prescriptive nature of the financial and administrative conditions attached to program funding Agreements and the Non-Insured Health Benefits program.

#### **Highlights of Results 1996-2000**

The persistence of the Board in adhering to their policies and procedures to help guide them in their formal relationships with the employees, community members and Chief and Council provided a sufficient measure of sustainability for them and the organization. For example, the policy direction for the employees to display respect and neutrality in their work and not get involved in local politics unless they were going to take a leave to participate as candidates in local elections also helped facilitate better relations with the community and neutralized to some extent the politics inherent in Band elections.

<sup>233</sup> PBCN, Health Care Needs Assessment For the Members of The Peter Ballantyne Cree Nation Living At Deschambault lake, Saskatchewan, July 1991, PBCN, Pelican Narrows, Sask.: 1991, 23, report by Jackie Carter and Diane Martz under "medical transportation."

<sup>234</sup> PBCN, Health Care Needs Assessment For the Members of The Peter Ballantyne Cree Nation Living At Southend, Saskatchewan, August 1991, PBCN, Pelican Narrows, Sask.: 1991, 25, report by Jackie Carter and Diane Martz under "medical transportation."

<sup>235</sup> Northern Intertribal Health Authority, Consultant Reports, 1998-99, "Medical Transportation Services," NITHA, Prince Albert, Sask.: March 31, 1999, 20

According to the 1996-2000 PBCN Health Annual Reports,<sup>236</sup> PB Health had attained balanced budgets every year. In 1996-97, the power and role issues were still a concern for the Board and some Portfolio Councilors particularly with overriding authority of the Board over the Chief and Council in matters of health administration. The Board response was to refer back to the political mandate given by Chief and Council to manage the Health Transfer on their behalf and that issues, such as personnel problems, would be addressed by administrative policies rather than on an individual basis. The resolving of personnel matters, such as employee discipline, was one area where it sometimes crossed political and administrative boundaries. Although personnel and administration policies were developed and approved by the Board and Portfolio Councilors, how they were implemented often created conflicts between staff and managers and sometimes were taken through the political channels by the staff, even by those who were not Band members.

Most situations were resolved through the reviews and assessments provided in the policy manuals, but the processes were hard on an emotional level for all involved and created undesirable stressful environments. Nevertheless, some of the lessons learned for the administration and Board in going through these cases illustrated the importance of keeping proper documentation for helping determine facts and assumptions, the value of using tact and diplomacy in communication and importance of consistently implementing organization policies and procedures. In 1996-97, the power and role issues were still a concern for the Board and some Portfolio Councilors particularly with the overriding authority of the Board over the

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<sup>236</sup> PBCN Health Services Inc., *PBCN Health Services Inc., 1996 to 2000 Annual Reports*, Prince Albert, Sask.: PBCN Health Services Inc., 1996 to 2000



Chief and Council in matters of health administration. The Board response was to refer back to the political mandate given by Chief and Council to manage the Health Transfer on their behalf and that issues, such as personnel problems, would be addressed by administrative policies rather than on an individual basis.

Board concerns with the MSB non-insured health benefits programs, especially problems associated with transportation coverage, were often raised to MSB with limited success; therefore, alternative Band aid measures had to be found. In Pelican Narrows, for example, a meal travel program was developed to supplement the inadequate meal coverage for patients traveling to the cities for medical appointments or hospital services. However, because medical transportation coverage was based on national policies, it was hard for the Board to influence the criteria in any meaningful way. Another example of a cost-sharing initiative, not covered by MSB, was the decision by Health and the Band Administration to purchase vehicles for elder's transportation services.

PB Health was also involved in developing innovative regional partnerships for efficiency and quality improvement purposes. The Board recommended that the PBCN Chief and Council sign the letter of understanding establishing the Northern Intertribal Community Health and Surveillance Unit along with the Meadow Lake Tribal Council, the Prince Albert Grand Council and the La Ronge Indian Band.

Enhancing local health programs and services were a priority for the Board. New measures were taken for health center security by hiring new security personnel in the communities on a pilot basis since there was no funding at the time under the Transfer. Concerns with break and enters and vandalism especially during the

weekends and summer months initiated these measures. A mental health therapy program was also developed, but due to limited MSB funding, therapy services for all the communities were contracted to one therapist based out of Pelican Narrows. New elder programs were added with the hiring of elder coordinators who were responsible for providing various kinds of social and health support services for elders in their communities. New youth programs were also developed with the hiring of youth coordinators to provide social and health education activities and projects for youth. Regular youth activity nights were organized every week in the communities and annual regional youth conferences were started in 1996.

Summer Camp programs were also developed in each of the communities providing opportunities for children organized according to various age groups to participate in organized recreational and health education activities geared to promoting positive lifestyles. There were some problems in the first few years of summer camps involving organization and control issues. One of the problems was that the camps were too big with 50-60 children and insufficient staff complements. Problems with discipline, lack of clear job duties, poor scheduling and exhaustion led to many community complaints. These were improved when camps were later organized under more manageable group—staff complements with 20-25 children supervised by 4-5 staff.

Local health facilities were also enhanced. Capital facilities development included adding new trailers for nurses in Southend and new office infrastructure such as telephones, printers, fax systems and new filing systems were set up in all the clinics. Minor renovations were done in the older clinics.

1997-98

Training was a priority for the Board for capacity building and local staff development. A new 3 year core-training program was set up as part of an education and training strategy for community staff. It was organized through accredited modules taught by the senior managers for one-week rotations in the communities. The curriculum consisted of orientation, basic skills, computer skills, body systems and personal development I and II, developmental stages and Indian Studies. A new home care (on the job) training program was also started for the home care staff in coordination with the Core Training program. The home care specific training included personal care for clients, transfers, lifts, charting and reporting, foot care, holding workshops, and according to nursing client assessments, proper follow up was a concern for elders with their eye and dental appointments, their medication, equipment such as bath supports in their homes, and there were also similar problems with the lack of support and rehab services for people with disabilities. To promote higher education initiatives, educational scholarships were also awarded by the Board to 10 PBCN students enrolled in health-related post-secondary and technical programs.

Telehealth services were identified as another key development for capacity building and quality enhancement of local health services. A proposal was submitted to MSB for the development of a telehealth pilot project in Southend. Other priorities for which funding proposals were developed included the improvement of dental services which were largely itinerant services at best with most people having to see dentists out of town.



Capital service improvements were a continuing priority as infrastructure developments in the health facilities occurred. A heated garage was built for the ambulance vehicle in Pelican Narrows, an addition was built to the Deschambault Lake health center and renovations were done in Southend and both were financed through surplus operational funds.

A regional health staff conference was also held in Prince Albert during this 1997 period to review progress with Transfer programs and the feedback from the conference was generally positive. In the mental health services area, successes included new programs such as women and men wellness, AA groups organized, Alateens, healing circles, community family nights, summer elder and youth camps, guidance counselors in schools. Some challenges included concerns with the itinerant and poorly funded mental health therapist service and lack of treatment centers and proper follow up for clients. In the non-insured health benefits program, while training was provided for transportation clerks in the communities, there were also many concerns regarding the implementation of unpopular MSB travel and financial policies. Other benefits such as dental services were seen as limiting due to lack of consistent dental therapy programs in the communities. There were also some concerns with security needs for the health facilities.

In home care services, successes included staff training and the emphasis on a holistic caring approach by workers for people with chronic illnesses. Challenges included more staffing and supports for special needs clients and improved care for elders especially in cases of potential financial and elder abuse. One of the top concerns had to do with the need for 24 hour care Nursing homes in the communities

to keep the elders in their communities. Other concerns included transportation for elders along with more home visits and respite services. In environmental & occupational health services, successes included the better monitoring of water resources with the hiring of water technicians by PB Health which coincided with the Band water and sewer and housing developments. Safer working environments were developed including anti-smoking rules in health centers, good equipment supplies and monitoring and training for the handling of dangerous goods and storage. Challenges included better shoreline clean up programs, policies on contaminated grounds such as gas spills, dog control and overcrowded housing problems. Some also felt that environmental bylaws were needed along with more community workshops on environmental cleanliness and safety. The improvement of poor housing conditions was also perceived as a major health-related need.

In relation to community health education programs, successes included increased participation by health committees in education workshops (stress control, exercise and nutrition), better coordination with local service agencies and more local Band staff managing programs. Challenges included ongoing problems with drug and alcohol abuse, better training, and the need for proper children's programming. Most thought community newsletters and other forms of local information distribution were needed.

In community health nursing, successes included improvements with the chronic program where staff worked more as teams in health promotion to teach clients about proper diet, exercise, and medication. Teen parenting programs were taught in school with women elders teaching young women and men elders teaching young boys and

men. Some challenges included the need to provide transportation for those who could not come to the health centers by themselves and some felt that nurses needed to make more home visits, and for community staff to better their communication and translation skills for clients. Many also thought youth centers needed to be set up in communities with organized activities.

In the holistic health program, successes included better assessments, counseling, referrals, AA meetings and health education activities such as dry dances and youth conferences. The counseling services, workshops and organized youth and school programs were considered to lessen crime and vandalism. Challenges included more culturally appropriate mental health programs and education for community staff, more elders input into the programs, better interagency coordination, and better access to treatment and rehab programs. In the communicable disease control program, successes included better monitoring and increased public education in schools and community workshops on communicable diseases. Challenges included the need for continuity of care in the programs and more public education in areas such as AIDS.

Community development was a considered a key theme in all the programs as well as in the administration of health services. An organization restructuring to decentralize more management functions to locally-based health coordinators was done and with their expanded roles, health coordinators were changed to health directors and became part of the regional management team directly reporting to the Executive Director. A new administrative position was also created in Pelican



Narrows to help the health director manage the bigger demands of a larger health center and population.

#### 1998-1999

Holistic health services are seen as the key to mental health and wellness support. In the holistic health programs offered by PB Health, psychological-social programs provided that support through addiction programs like NNADAP, community-based funding programs (Brighter Futures), AIDS, Mental Health, Family Violence and the new Aboriginal Head Start Program. The Holistic Health team included holistic health coordinators and holistic health intervention workers and the youth workers and elder coordinators. New holistic health coordinators were hired in each of the communities, most were First Nation and one from the PB Band. These were social work level employees who replaced the former MSB mental health therapists. Their work involved coordinating the holistic health programs, providing crisis intervention services, individual and group counseling, some assessments, program development and referrals.

Several holistic health intervention workers also graduated from a 2 year Community Services and Addictions training program offered by the Saskatchewan Indian Institute of Technologies – all of which they took for one week each month for 2 years in Saskatoon.

Community reports noted growth in the number of programs offered by holistic health such as men's and women's support groups which are well attended and more time spent on outreaches through school and home visits.

Nursing retention issues posed a continuing challenge with changes required for competitive nursing recruitment strategies. To address the nursing needs, PB Health worked in cooperation with the NITHA partners to develop an Aboriginal Nursing School in Prince Albert through the Saskatchewan Indian Federated College. New program developments in 1998 also included a water fluoridation project which was proposed in each of the communities following extensive community consultations.

In the home care program, on a broader level, PBCN Health was instrumental in helping the provincial First Nations Home Care Working Group provide considerable input and experience into the national MSB framework document for Home Care which was designed to develop national standards and policies for home care services on reserves. In relation to new program developments in the communities, home care workers became integrated into the PB health team, moving from their previous locations in the Band offices to the community health centers. Challenges in home care services included the Board's inability to meet the increasing demands from the communities for some sort of facilities for on-reserve care for the elderly or people with special needs who do not wish to leave their community. Needs assessments were completed for developing funding proposals, but funding resource problems continued to be unresolved.

For Capital improvements for 1998, building renovations for the community health centers and inventory counts were done thus resolving many of the maintenance problems especially those associated with power outages. New capital improvements included a residential trailer for Pelican Narrows, treated wooded

fence for Deschambault and air conditioning and vehicle for Southend. A new one-year telehealth pilot project was also approved for Southend with goals to increase access to health-related education and information in more efficient ways such as general consultations, mental health and diabetes education. Preparations for potential problems for Y2K were also done including the inventory of medical supplies and equipment, and the purchasing of back up generators with 2-week fuel supply in event of power failures.

Other new initiatives for 1998 included participation in the development of a First Nations Health Information System funded by MSB to develop a database system for client case management and health status surveillance. A dental therapy pilot program was also established in Pelican Narrows under the coordination of a dental therapist and dental assistant. Programs such as preventative dentistry with the school and community were set up, and clinical dentistry services were provided including fillings, sealants, x-rays, cleaning, extractions and emergency services. Referral services continued to be made to dentists in the nearby cities. Also field dental teams from the Saskatchewan Indian Federated College dental therapist program offered regular services to the communities through an agreement with PB Health.

#### 1999-2000

One of the key accomplishments for the Board in 2000 was the renewal of the Transfer Agreement by MSB for another 3 years. Other developments continued to build on existing programs in the communities. In the holistic health program, for



example, databases were developed to track statistical information for future program planning

Community participation was evidenced by increased staff and community health committee collaboration in the annual planning of health programs and budgets with support from the central office management team. There was certified training offered for staff and community members in suicide prevention by the holistic health coordinators.

The Aboriginal Head Start Program was approved for funding in each of the communities resulting in accelerated cooperation between the interagency committees who were involved in program development, budgets, curriculum, renovation and new construction of buildings, supplies and hiring staff. An annual staff conference was held in Prince Albert which involved the Chief and Council, Elders, youth, Board, health committees and staff. The PBCN/SIIT Health Sciences Core Training Program that began in Sept 1997 with 35 registered students (mostly health staff) was completed with 23 successful graduates. This was followed by the next phase of training that was separate and specific to the different programs. Physicians' salary-based contracts were negotiated between PB Health and multiple government funding agencies replacing the former fee-for-service system, which had proven unsatisfactory. It allowed parallel clinics to be held by nurses during doctor days, thus freeing up the doctors to concentrate on more serious medical conditions. New Pharmacy services were added in Pelican Narrows with the contracting of a visiting pharmacist from the PBCN pharmacy in Prince Albert.

Nursing services continued to prove challenging. Nursing alternatives such as nursing program assistants and licensed practical nurse positions were hired on a pilot project basis to take over the non-treatment duties required of nurses. As well, increasing salary grids, on call changes and training and orientation initiatives were all part of the nursing retention strategy. The relief pool remained stable, which was vital for replacing staff on educational or personal leaves. Once a month nursing services were also added to the new reserve community of Kinoosao, located north of Southend. Plans for setting up a clinic staffed by a community health worker were developed, and established by 2001.

Community Fluoridation projects were completed with maintenance staff in place.

The telehealth pilot project for Southend was approved as a national research project by Health Canada. The project provided opportunities for local staff to be trained in operating the service and improved communication services to help with patient compliance with specialist appointments, education, and access to the provincial telehealth network. What was most visible was the installation of videoconferencing capabilities in other communities such as Pelican Narrows and Deschambault Lake. Health committee meetings could now link with the senior managers for improved communications between central office and the local health centers. Some of the disadvantages were the high costs and maintenance requirements associated with the telehealth technology and equipment. The response to the technology by the local health committees and Board was mixed. The health committees used the videoconferencing services more frequently than the Board. The Board preferred to

have face-to-face monthly meetings because they believed that it was important to meet together to deal with things, especially sensitive and confidential matters, as a group. Video conferencing in this respect was treated similarly like telephone conferencing. The Board used it for emergency purposes rather than for their regular monthly meetings.

### **PBCN Health Transfer Evaluation**

One of the requirements of the PBCN Transfer was to have an evaluation Report done in the final year of the Agreement on the "effectiveness of community health programs" with a copy submitted to the Minister (MSB).<sup>237</sup> An independent contractor<sup>238</sup> was subsequently engaged by PB Health Services in late 1999 to conduct the evaluation for the April 1, 1995 - March 31, 2000 period. While the contractors found that the mandatory transferred health services were in place in the communities, they reported that quality assurance was hard to determine from the information available through the nursing daybooks.<sup>239</sup> This was in reference to the "community workload increase system" or CWIS which MSB used as a national data gathering mechanism primarily used for tracking nursing workloads in First Nation communities in order to determine funding allocations.<sup>240</sup>

This data collection system that had been used by MSB over the years to help

<sup>237</sup> The Minister of National Health and Welfare, The Peter Ballantyne Band, The PBCN Health Services Inc., The Health Service Transfer Agreement, 1995, Prince Albert, Sask.: 1995, s.35, 17

<sup>238</sup> The Contractor was Northern Medical Services, Department of Family Medicine, College of Medicine, University of Saskatchewan, and the Evaluation was submitted December 5, 2002

<sup>239</sup> PBCN Health Services Inc., Peter Ballantyne Cree Nation Five Year Evaluation of Health Transfer, Prince Albert, Sask.: PBCN Health Services Inc., NMS, Department of Family Medicine, University of Saskatchewan, 2002, 8

<sup>240</sup> Minister of Health, Health Canada, Ten Years of Health Transfer: First Nation and Inuit Control, Ottawa: Minister of Public Works and Government Services Canada, 1999, 7



determine funding formulas, and continued to be used by PB Health in the absence of alternative data systems, only tracked aggregate workloads for nursing staff and did not track health outcomes, who delivered what and how it was delivered.<sup>241</sup> It was also noted that the reporting was inconsistent and incomplete<sup>242</sup> which made the available data limited to providing descriptive information rather than quality assurance. The report stated:

The data currently being provided by MSB, Health Canada, needs to be more specific. An example of this is that the highest number of visits in June, 1999 in Pelican Narrows was by 25-44 year olds but we do not know gender, for what, number of visits by any one individual or the outcomes of the treatment provided. Health promotion planning may be necessary but that would be very difficult to identify from the data set available.<sup>243</sup>

Limited by the absence of a sound data base system from which to extrapolate changes to the health status of the communities, the evaluation was limited to literature reviews and community surveys where people were asked to identify what they felt were the strengths and gaps in health services since Transfer and their views about their own health status. Heads of households (18 years and older) residing in the Transfer communities were invited to participate in the community surveys and 446/727 responded which at 61% was a good representation of the sample population.<sup>244</sup> The positive outcome of the evaluation, in spite of its limitations, was that it provided some insight about community awareness and satisfaction with the

<sup>241</sup>PBCN Health Services Inc., Peter Ballantyne Cree Nation Five Year Evaluation of Health Transfer, 2

<sup>242</sup>PBCN Health Services Inc., Peter Ballantyne Cree Nation Five Year Evaluation of Health Transfer, 2

<sup>243</sup>PBCN Health Services Inc., Peter Ballantyne Cree Nation Five Year Evaluation of Health Transfer, Prince Albert, Sask.: PBCN Health Services Inc., NMS, Department of Family Medicine, University of Saskatchewan, 2002, 11

<sup>244</sup>PBCN Health Services Inc., Peter Ballantyne Cree Nation Five Year Evaluation of Health Transfer, Prince Albert, Sask.: PBCN Health Services Inc., NMS, Department of Family Medicine, University of Saskatchewan, 2002, 25

health services since Transfer. As well, the high response rate to the surveys was a positive indication of the collaborative research processes that were used by the contractors in working with the Board and health staff in the communities and the hiring and training of local coordinators and surveyors to conduct the surveys.

The evaluation report was organized into various sections that are summarized here in order to show the relative level of success achieved by the Board and PB Health in not only meeting the basic requirements of the Transfer Agreement but also doing far more than what was expected with the addition of new programs such as telehealth and other specialized kinds of services in the communities. It also reflects the general political support and legitimacy that the Board was able to build during the first five years of its mandate. The evaluation survey was organized into various categories, namely, general outcomes, mandatory program requirements, community-based programs and general levels of satisfaction in relation to the provision of medical and other health-related services by PB Health. What these categories reflect are a useful summary or snapshot of much of what has already been described previously in the case study discussions.

*General Outcomes:*<sup>245</sup>

The general outcomes described the primary health services required under the Transfer Agreement. The environmental health officer services were contracted with the Prince Albert Grand Council as part of the terms of MSB. The Medical Health Officer Services also continued to be contracted out first with the province and then with the Northern Intertribal Health Authority. The Pharmacy services and

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<sup>245</sup> PBCN Health Services Inc., *Peter Ballantyne Cree Nation Five Year Evaluation of Health Transfer*, Prince Albert, Sask.: PBCN Health Services Inc., facilitated by Northern Medical Services, Department of Family Medicine, University of Saskatchewan, 2002, 6

consultation services were first provided through contracts with different companies, but when PB Health set up its own pharmacy, it was able to provide its own services.

| <b>Environmental Health</b>                                                                                                                                           | <b>Medical Health Officer<sup>246</sup></b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | <b>Pharmaceutical Services and Consultation</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <p>– the Environmental Health Officer<sup>247</sup> from the Prince Albert Grand Council provides the services to PBCN through a Contribution Agreement with MSB.</p> | <p>In 1995-1997, the MHO services were contracted with Northern Medical Services<sup>248</sup> out of Lac La Ronge and administered by the MSB regional office.</p> <p>In 1997, with the creation of the Northern Inter-Tribal Health Authority, MSB transferred funding and responsibility of MHO services from Northern Medical Services to NITHA. A special unit called the "NITHA Community Health Status and Surveillance Unit (CHSSU)" was set up with the hiring of an MHO, a nurse epidemiologist and a data entry clerk.</p> | <p>Prior to transfer, the pharmaceutical and consultation services and medical supplies were provided to the community clinics through contracts with independent pharmacies located in Flin Flon, Manitoba, Lac La Ronge and Prince Albert.</p> <p>In 1995, a company with PB Health as one of the three shareholders set up a PBCN pharmacy and took over the provision of pharmaceutical services and consultations to the PB communities.</p> <p>In 1999, with the high volume of prescriptions placing additional workloads on nursing staff in Pelican Narrows, a pharmacist and pharmacy technician were subsequently contracted to take over the pharmacy duties and improve pharmacy services.</p> |

<sup>246</sup> MHO

<sup>247</sup> EHO

<sup>248</sup> NMS



*The 3 Mandatory Programs Required:*<sup>249</sup>

The report generally confirmed that all mandatory-transferred services were in place in each community as required.<sup>250</sup>

1. Communicable Disease Control

| <b>Counseling Services<br/>Given</b>                                                                                                                 | <b>Screening Services<br/>Given</b>                                                                          | <b>Treatment Given</b>                                                                                                                         |
|------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------|
| <ul style="list-style-type: none"> <li>- CDC</li> <li>- Sexually Transmitted diseases</li> <li>- TB and follow-up</li> <li>- HIV and AIDS</li> </ul> | <ul style="list-style-type: none"> <li>-Rapid Classroom Inspection</li> <li>- Tuberculosis Screen</li> </ul> | <ul style="list-style-type: none"> <li>- Sexually Transmitted Diseases</li> <li>- Hepatitis</li> <li>- Parasitic Diseases (general)</li> </ul> |

2. Treatment

| <b>General Services Given (from itinerant data from nursing reporting system)</b>                                                                                                                                                                                                                                                                                            |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <p>Eye, Ear, Throat, respiratory (upper, lower), gastrointestinal tract, genitourinary, cardiovascular, musculoskeletal/connective, endocrine/metabolic, obstetrics/gynecology, neurological, hematological, skin/mucous membranes, dental, sexually transmitted disease, hepatitis, parasitic disease (general), psychiatric, pyrexia, minor procedures, death-related.</p> |

3. Community Emergency Response Plan

| <b>Emergency Response Initiatives</b>                                                                                                                                                                                                                                          |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <ul style="list-style-type: none"> <li>- Community-based emergency response plans developed in the communities</li> <li>- In 1996, PB Health together with the PBCN Band set up an ambulance company based in Pelican Narrows and contracted the emergency services</li> </ul> |

<sup>249</sup> PBCN Health Services Inc., *Peter Ballantyne Cree Nation Five Year Evaluation of Health Transfer*, Prince Albert, Sask.: PBCN Health Services Inc., facilitated by Northern Medical Services, Department of Family Medicine, University of Saskatchewan, 2002, 7, 8

<sup>250</sup> PBCN Health Services Inc., *Peter Ballantyne Cree Nation Five Year Evaluation of Health Transfer*, *ibid*, 10

and personnel from an ambulance company from Prince Albert.

*The Community-Based Health Programs*<sup>251</sup>

The community-based programs basically consisted of lists of medical treatment and counseling requirements and were useful insofar as giving an idea of what services were expected, but not so useful as far as giving any idea in relation to quality issues. Some of the counseling services required included: Things like:

| Counseling services Given | Screening Services | Examinations | Referrals | Administration | Immunization |
|---------------------------|--------------------|--------------|-----------|----------------|--------------|
|---------------------------|--------------------|--------------|-----------|----------------|--------------|

Counseling Services Given

- Maternal and child health
- Family and sex education, communicable disease control, sexually transmitted diseases
- Tuberculosis and follow up
- Child abuse/neglect, family relationships
- HIV/AIDS -- safety and accident prevention
- Chronic Care
- Nutrition
- Dental health
- Alcohol and drug abuse
- Mental health
- Occupational health
- Lifestyle
- Environment
- Acute illness
- Allergy
- Palliative and homecare

Screening Devices

- Vision, hearing
- Height and weight, development testing
- Rapid classroom inspection
- Child health clinic
- Blood pressure and hypertension
- Tuberculosis screen, blood glucose

Examinations

- complete physical
- Complete pre-natal
- Partial physical

<sup>251</sup> PBCN Health Services Inc., Peter Ballantyne Cree Nation Five Year Evaluation of Health Transfer, op.cit., 8- 10

- Pap smear-lab tests, x-ray
- Other screening

#### Referrals

- Doctor
- Hospital
- Emergency medevac
- Social services from Band or Province
- Dental health
- Mental health
- Optometrists, ophthalmologist
- All Band services
- Home care with Band and Province
- Sask Health
- Admissions

#### Administration

- Aids to daily living
- Home visits
- Health Canada or MSB visits
- Liaison
- Referrals and follow up

#### Immunization

- DPT
- Flu Vaccine
- Haemophilus influenza B
- Oral polio
- Measles, mumps, rubella
- DT children
- TD adults
- Tuberculosis
- Pneumococcal
- Other immunizations, reactions

#### Expanded Services

Some of the new services profiled in the evaluation included the Health Science Core Training Program.<sup>252</sup> The program was established in September 1997

<sup>252</sup> PBCN Health Services Inc., Peter Ballantyne Cree Nation Five Year Evaluation of Health Transfer, op.cit., 10



and it was an agreement between PB Health and the Saskatchewan Indian Institute of Technologies. It offered an accredited, community-based training program for community health staff and other interested community members. The core-training program consisted of 13 modules from SIIT and 4 from PB Health. Another training initiative included the development of the PB Health Scholarship program where scholarships were awarded annually for PB members in health-related fields.

#### General Satisfaction

| <b>Satisfaction with provision of medical services<sup>253</sup></b>                                                                             |
|--------------------------------------------------------------------------------------------------------------------------------------------------|
| <ul style="list-style-type: none"> <li>- 74.5% indicated services were adequate</li> <li>- 25.5% indicated services were not adequate</li> </ul> |

| <b>Satisfaction with Holistic Health Services – Addiction, Counseling, mental health<sup>254</sup></b>                                                                                                                                                                                                                                    |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <ul style="list-style-type: none"> <li>- 79.7% indicated there were services available in the community if they needed help with addictions; 20.3% indicated there were not enough services available</li> <li>- 68 % indicated there were services available if they needed help with mental health concerns and 32 % did not</li> </ul> |

#### **Conclusion**

In summarizing the power relationships between the Board and the other signatories to the Transfer Agreement, it was clear that the Board was subordinate to both MSB and the Chief and Council. On the one hand, they were accountable to

<sup>253</sup> *ibid*, 30

<sup>254</sup> *ibid*, 32

MSB largely for meeting the accounting and program requirements for the funding they provided, and on the other hand, they were accountable to the Chief and Council on a much broader political scale with respect to their methods of delivering services, including personnel practices, program planning strategies, methods of public input and reporting. The accountability to MSB was met through the submission of regular financial and program reporting on the various programs and through the annual reports and audited financial statements done every year. The accountability to Chief and Council was more interactive through Board meetings, formal personnel and operational policies and procedures, and informal networks at the community levels. As time passed and the Board gained more experience and was able to weather the storms, the relations between the Board and both MSB and Chief and Council also matured as a result of the Board becoming better understood and trusted.

In their 5 years of operations, the Board steered the organization through several Band elections without losing the political support of both the former and newly elected leadership. This support was evident in the help that the Board received from the Chief and Council in successfully negotiating the renewal of the Transfer several more times from 2000-2003 and 2003-2008. It demonstrated a certain level of political acceptance and credibility with the Board model of governance by both the federal government and Band partners in the Agreement. The fact that the Board was able to demonstrate fiscal responsibility through balanced budgets throughout the 5 year period also helped lend credibility to the Board's governing competence to continue their work.<sup>255</sup> The message by the Chief in the 2000 annual report reflected

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<sup>255</sup> PBCN Health Services Inc., *Annual Reports, 1995 to 2000*, PBCN Health Services Inc., Prince Albert, Sask.: 1995 to 2000

this acceptance and sense of ownership and ongoing commitment by the political leadership for the Board and organization. He stated:

"This past year has been an eventful year for the Peter Ballantyne Cree Nation. It was five years ago that we took over our medical delivery for Pelican Narrows, Southend, Deschambault and Sturgeon Landing. We have now renewed our Health Transfer Agreement for another three years...The excellent work that has been done by the Board, Portfolio Councilors and staff of PBCN Health Services in the past five years proves that our own people are best able to manage and provide medical services to the Cree Nation...All in all, I am proud of the work that has been done in the past five years and look forward to working with everyone to build our health system so that we can provide quality services to our communities for many years to come."<sup>256</sup>

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<sup>256</sup> PBCN Health Services Inc., Annual Report, 2000, PBCN Health Services Inc., Prince Albert, Sask.: 2000



## CHAPTER 8 CONCLUSION

### Introduction

The topic of this thesis is about an emerging form of First Nation corporate governance in public service delivery as illustrated by the evolution and governance experiences of the Peter Ballantyne Cree Nation Health Services organization and its Board of Directors during 1995-2000. The general research question asks what was the experience of the Board and organization after five years of operation under the PBCN model? The specific research questions ask: Why did it evolve the way it did? What were the advantages and challenges of the model and what implications does it suggest for further study?

The conclusions suggest that in the case of the Peter Ballantyne Cree Nation, the experience of the Board was a positive one. It essentially confirmed the Chief and Council's decision that PB Health Services Inc., as an autonomous and separately funded non-profit health organization governed by a non-political, community representative Board of directors, offered significant advantages for enhancing the overall quality of their health system as well as providing more opportunities for public participation and capacity-building in local governance and administration. Much of this was evidenced by the Board's successful renewal of the initial PBCN Agreement several times over (2000-2003 and 2003-2008) speaking to the Board's ability to satisfy the terms of the initial Agreement and to gain governing credibility in the eyes of the Chief and Council and MSB.

This chapter presents a narrative analysis of the Board's experiences and provides conclusions on the merits and challenges of the PB Health model as a

vehicle for enhancing local health services and self-government, all of which further allude and perhaps can contribute to the developing literature around notions of good governance. The discussions are organized in a similar fashion as the thesis framework. First, the introduction provides an overall summary of the case study findings in relation to the conceptual approach taken, the outcomes of the Transfer, the lessons learned and the study's potential contributions to First Nation governance. Second, the Board's experiences in governing PB Health are discussed and analyzed in relation to the emergent themes of power and authority, relationships, accountability and political culture. Third, the chapter closes with a brief conclusion of the answers to the questions in the case study and comments on potential topics for future study.

Overall, the Transfer experience of the PB Health Board and organization is valuable in terms of informing a gap in the literature in relation to the governing of First Nations organizations,<sup>1</sup> especially in terms of how this Board operated during a 5-year period in spite of changes to Board members, Chief and Council and staff. However, it should be clear that because it was a single case study, its general application is necessarily limited. It cannot be inferred that setting up a non-profit organization with separate funding and governed by an apolitical community Board will work in all First Nation communities. Neither can it be said that PB Health is a "traditional" health model thus implying some kind of institutional superiority to others. Although the guiding documents for PB Health are based on popularly espoused traditional values such as respect, kindness, sharing and equity, the delivery

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<sup>1</sup> Young David E. and Leonard Smith, 1992, Robert Depew 1994, T. K. Young, 1994, Noel Dyck, 1991, Frank Cassidy and Robert L. Bish 1989

system is largely a reflection of contemporary community processes and western administrative, legal and medical practices. It emphasized sound fiscal administration, organized health services at the community level, as well as various kinds of systemic inclusion in decision-making with the other key players in health through formal and informal organization policies. Just how traditional or culturally appropriate the PB Health model is remains inconclusive, although there are clearly some 'past' influences such as the PB Board's emphasis on family, community, elders, prayer, language, and working together which may be considered 'traditional' according to some of the features described in the literature on hunting and gathering societies.<sup>2</sup> As an institutional framework, the corporate model worked out well politically and administratively for PBCN according to the PB Health annual reports, but the extent to which it reflects 'traditional' values is questionable. This is not unique to the PB case. Scholars generally recognize that the concept of tradition itself is confusing and there is no shared framework or agreement as to its meaning. Some note that "we can no longer think of tradition as forming an integrated whole. It is a mixture of past and present."<sup>3</sup> Some suggest that policies and procedures of contemporary Aboriginal systems may never be culturally appropriate and may lead to the appropriation of cultural traditions for administration ends,<sup>4</sup> but others imply that Aboriginal organizations with a "collectivist" orientation based on traditional Aboriginal values

<sup>2</sup> Leacock Eleanor, Richard Lee, Eds., Politics and History in Band Societies, Cambridge: Cambridge University Press, 1982, 8, 9; also, Buckley Helen, J. Kew, John Hawley, The Indians and Metis of Northern Saskatchewan, A Report on Economic and Social Development, Saskatoon, Sask.: Center for Community Studies, 1963

<sup>3</sup> McDonnell R.F. and R.C. Depew, "Self-Government and Self-Determination in Canada: A Critical Commentary," in Hylton, John H., ed., Aboriginal Self-Government in Canada: Current Trends and Issues, Second Edition, Saskatoon, Sask.: Purich Publishing Ltd., 1999

<sup>4</sup> Lynes David A., "Cultural Spirit and the Ethic of Bureaucracy: the Paradox of Cultural Administration," Canadian Journal of Native Studies, Vol.15, 1, 1995, 75-88



will more likely involve elders as teachers and advisors and create a "group oriented, non-hierarchical organization which operates by consensus and encourages holistic employee development."<sup>5</sup> Others implicitly interpret the meaning as some kind of more meaningful individual and "community" empowerment through participation in decision making.<sup>6</sup>

The PBCN history illustrates some of the changes wrought by colonial and other factors of change, with its Band government system that formalized and replaced the past way of life of the PBCN people. What these changes implied for the self-determination efforts by PBCN in the health transfer was that the PB Board took over a colonial legacy of health problems, dependencies and afflictions associated with the cumulative loss of personal, social and economic power. The pressing medical needs of the communities forced the Board to focus more on the essentials of medical treatment services rather than prevention and other forms of education, although the goal was always to have less treatment and more prevention. The PB people wanted quality health services and more say in the decision-making. Therefore, much time and resources were invested in the recruitment and retention efforts of medical personnel, the employment and professional development of Band member personnel and community participation through public meetings, workshops and other kinds of outreach.

<sup>5</sup> Chapman Ian, D. Newhouse, D. McCaskill, "Management in Contemporary Aboriginal Organizations," in *Canadian Journal of Native Studies*, 7(2), 1991, 333-349

<sup>6</sup> Young T. Kue, *Health Care and Cultural Change: the Indian Experience in the Central Sub arctic*, Toronto: University of Toronto Press, 1988, 135; also, Dacks Gurston and Ken Coates, Eds., *Northern Communities: The Prospects For Empowerment*, Edmonton, Alberta: Boreal Institute for Northern Studies, The University of Alberta, 1988, 9; also, Institute on Governance in collaboration with York University, CESO Aboriginal Services, Saskatchewan Indian Federated College, *Understanding Governance In Strong Aboriginal Communities, Phase One: Principles and Best Practices From the Literature*, October 12, 1999, Ottawa: IOG, 1999, 9

What the case demonstrates clearly is that First Nation governance is a complex and growing reality and with the continuing pursuance of self-government, it is imperative for governing authorities and service organizations to develop sustainable institutional processes and mechanisms just to try to meet basic community needs, deliver the required essential services under the funding Agreements and to balance the complex environment of political and administration relationships, power, accountability and political culture. Hopefully this case will inspire more scholarly interest in studying and expanding the scope of knowledge around First Nation governance by examining other kinds of governance systems that have developed in First Nation communities. It may be particularly useful for other First Nations considering health transfer to be informed about some of the lessons learned in the PBCN experience. The case might also have policy implications upon the health renewal initiatives by Health Canada in their endeavors to improve the health of First Nations and Inuit people and to better manage the public funds and programs targeted for them. The complex issues associated with healthcare such as affordability, accountability and sustainability remain, after all, a concern for all.<sup>7</sup>

#### **Summary of Results (1995-2000)**

The PBCN Community Health Plan provided the overall vision and guiding principles for the Board and organization to use for strategic planning and policymaking. The long-term plan of Transfer was to build a comprehensive or holistic health system for the PBCN Transfer communities.<sup>8</sup> While this analysis of the

<sup>7</sup> Health Canada, *Ten Years of Health Transfer: First Nation and Inuit Control*, Ottawa: Minister of Public Works and Government Services Canada, 1999, 19

<sup>8</sup> The *PBCN Community Health Care Plan, 1995* was an initial requirement in the pre-transfer process and it outlined a general direction or 'map' for the Board to follow

Board model cannot provide direct correlative data or information to determine whether the Board's efforts resulted in changing or improving the health status of the PBCN people, what was evident in the various reports and evaluations, was that the Board not only succeeded in implementing the standard administrative and service requirements of the Transfer, but had expanded services over and beyond what was expected. Some of these accomplishments include the following:

- 1995-2000 PBCN Health Transfer Agreement renewed in 2000-2003
- Annual Report Requirements met each year showed consistent financial accountability with balanced budgets and surpluses each year
- Timely Transition in 1995 – 1996 with developed Personnel and Administration Policies and hiring of essential management and program staff.
- Stable administration structure developed through Board adoption of policy route in governance and management. By 2000, after 5 years of implementation, it was an accepted administration practice to operate under the guidelines of the personnel and administration policies that were essentially unchanged except for minor amendments.
- Fulfillment of Essential Services – the annual reports and Transfer evaluation reported that the requisite essential services were being delivered.
- Expansion of Essential Services - new services for elders, men, women, youth and children through programs like home care, various support and counseling groups, training opportunities for people in areas such as suicide intervention and First Aid, Aboriginal Head Start and others.
- New Partnerships with Band, Province and others added more specialized services to communities – negotiated and got salaried physicians rather than fee-for-service, developed a pharmacy with pharmacists providing support to clinics, set up an ambulance service to cover several communities.
- Generated local employment
  - 1995 - 1996: 49 new staff employed of which 29 or 59 % were Band members
  - 1999 - 2000: 84 staff employed of which 65 or 77% were Band members
  - By 2005: Total Employment 123 staff of which 93 or 75% were Band members
- Consistent Management developed



1995 – 1996: 16 managers overall of which 7 or 43% were Band members

1999 – 2000: 16 managers overall of which 7 or 43% were Band members, including the Executive Director

By 2005: 16 managers overall of which 7 or 43% were Band members

- Training & Development – 3 year Community Staff Core Training program established to upgrade essential skills with 23/35 graduates, some going on to nursing and social work.
- Increased Public Participation - annual conferences, health committees, interagency groups, support groups, and forums for youth and elders input in the development of annual community health center work plans and budgets.
- Capital improvements – new health facility in Pelican Narrows, and extensive renovations to facilities in other Transfer communities. New service technologies added with computers, telephones, and Internet and video conferencing capabilities in Pelican, Deschambault and Southend.
- Urban family services program added to support patients, families and children.

#### **Gaps**

Although the PB case was largely a positive experience, there were challenges and

service gaps that the Board could not address mostly because of external factors. The MSB Policies for funding formulas and program delivery were an example. The most direct effect of national MSB policies upon individuals was within the area of non-insured health benefits or NIHB. Non-insured benefits included provisions for some limited coverage for medical transportation, prescription drugs, eyeglasses, and dental care. The NIHB benefits were not part of the health transfer and continued to be managed by MSB. For some programs like transportation, contribution agreements provided funding for PB Health to hire transportation clerks to coordinate the services in the communities, and while it enabled better and timelier access for coverage, the MSB policy rules for transportation did not fit with community needs and expectations. Transportation clerks felt the brunt of people's frustrations with the

system because the coverage was insufficient and increasingly, the Band administration was supplementing the health service through special needs funds so that individuals could take a translator, for example, to medical appointments in the cities. Translator services had been cut in the transportation program.

The renewal of the health transfer was also affected by national MSB policies. The PB Board started their renewal negotiations a year prior to the 2000 deadline. When the time arrived for the Transfer Renewal in 2000, MSB was going through policy changes in response to requirements by the Auditor General for increased accountability in their programming and trying to balance their own fiscal restraint policies with the increasing national health costs. A national proforma (model, standard template) formula for health transfers was being proposed by MSB to create a standardized model for all the Bands across Canada, rather than negotiating with them individually. In response to this, the Health and Social Development Commission Chiefs from the Federation of Saskatchewan Indian Nations (FSIN) set up a working group to work out a Saskatchewan model. Since the process was promising to be lengthy, PBCN became concerned that their Transfer renewal would be held back and possibly jeopardize the continuation of health services in their communities. Although the PB leadership was supportive of the larger FSIN process and had a representative in the working group through their affiliation with the Northern Intertribal Health Authority, they felt that had to proceed on their own, and MSB agreed to examine their case on an individual basis which helped facilitate the renewal on time.

Data and information management was considered to be a weak area which needed further development in terms of internal technical capacity. Through participation with the FSIN- MSB Health Information System program, data clerks were hired in the communities to develop data base capacities for things like tracking immunization services. The Board through a redistribution of management funds hired a data programmer at the central office to conduct training, computer maintenance, and program development services for the community health centers. This position was able to provide much need computer technical help to the communities.

Other factors such as rising costs due to inflation, drugs and medical supplies, nursing and physician shortages, and population increases estimated at 4% a year, all challenged the Board in their management of health resources. They managed to keep within their budgets by having regular monthly budget and operational reviews and by providing consistent support to managers and staff through standard policies and procedures, competitive salaries, good benefits and innovative training opportunities. The Treaty Land Entitlement (TLE) process also created problems for PB Health in relation to the servicing of new reserves. Due to the policy and funding gaps at the national level with both INAC and MSB, new reserves like Kinoosao and Denare Beach were left without services when the province pulled out upon reserve creation. PB Health tried to address these gaps through extensive negotiations with regional and Ottawa-based officials and even defined a process through an "addendum" in the 2000 Transfer renewal, but as of 2005, the new reserves were still not part of the PB Health Transfer. What did occur, however, was a policy acknowledgement by MSB



to "have a process to deal with Treaty Land Entitlement (TLE) issues as they arise...based on (MSB's) resourcing policies for care programs."<sup>9</sup> The regional MSB office also provided some interim funding for PB Health to hire a community health worker in Kinoosao, secure office space and provide itinerant fly-in nursing services from the Southend health clinic.

### **Lessons Learned**

At the time of transfer, people were asked what kind of health system they wanted for themselves and their families. According to the pre-transfer community surveys, people were very concerned with the social and health problems caused by the alcohol and drug problems in their communities, especially with the youth, and they expected health to work towards developing more effective programs to address these needs. The major health needs summarized in the Community Health Plan included concerns with the environment, socio-economic issues such as the high unemployment rates which in a 1987 economic survey were reported as being over 79% across all PBCN communities, low education levels, the need for recreation facilities and programs, substance abuse and associated family problems, teen pregnancy, elder care, domestic violence and spousal assault, and morbidity and disease control.<sup>10</sup> The reports on the physician-hospital utilization trends indicated high sickness and injury rates in the PBCN population. High incidences were reported

<sup>9</sup> First Nations & Inuit Health Branch, Annual Report, First Nations & Inuit Control, 2000-2001, Ottawa: Health Canada, 2001, 1 under "accomplishments"

<sup>10</sup> PBCN, PBCN Community Health Care Plan, January 1995, PBCN Health Services Inc., Prince Albert, Sask.: 1995, 2-6

in respiratory illness, injuries, diabetes, gallbladder disease, hypertension, arthritis, thyroid disorders, recurring cases of tuberculosis, fetal alcohol syndrome and developmental delays in children. Concerns for more information on AIDS awareness were also identified.

In response to the challenges posed by these community needs, the experiences of the Board demonstrate that it is possible to achieve a certain measure of success in local governance in spite of the complex challenges in healthcare, especially in remote areas. Essentially, developing an organized health system and adhering to prudent administration principles and ensuring good working relations with the other players in the health system did this. The results of the PB experience indicate that the PB Board and organization were generally successful as far as being able to comply with the basic service requirements in the Transfer such as demonstrating prudent management and fiscal accountability through balanced budgets and providing the required medical and other mental and social programs. Employing appropriately qualified managers and essential staff, most of who were Band members and providing certifiable training opportunities, showed institutional capacity building. Implementing policies basically did arms length management with rules and procedures outlining clear roles and functions between management and the Board and between the Board and Chief and Council and others. Community services were enhanced by adding new programs to address the various health needs identified in the pre-Transfer survey such as elders and youth programs, men and women support groups, children's programs and expanded homecare services. Capital improvements added extensive building improvements to the health facilities and new

service technology resulted in videoconferencing capabilities through telehealth, computer training and data system development. New service partnerships with the province and others resulted in a salary rather than a fee-for-service system for physicians that allowed more time with patients. New business partnerships added more specialized services in the communities such as the PBCN pharmacy and ambulance. Urban programs were added with the urban family services program to help patients coming to Prince Albert for treatment. These were but a few of the accomplishments that the Board and others were able to do within the limited policy and fiscal confines of the Transfer Agreement.

While the Board successes in managing the Transfer can be attributed to many factors, some of the main lessons arising are worth noting. For starters, the legal and political foundation upon which the organization was built was a key one. The common political will and commitment by the Chief and Council and MSB to sign the tripartite Transfer Agreement including the Board as signatory, their support for the corporate governance structure of PB Health, and the autonomous financial and administrative control they gave to PB Health apart from the Band administration provided sufficient authority for the Board to build the organization with minimum political interference. This provided the best environment for the Board to maximize the opportunities to adhere to the requirements of the Agreement.

Board leadership was fundamental in terms of not only setting the organization direction and behavioral culture, but also for motivation and advocacy. The vision of the Transfer had to be articulated constantly on the Board and management agenda in order to keep everyone focused on the common mission of the



organization and the commitment to build quality health services in the communities. The PB Board chairpersons in particular had strong public profiles, community knowledge, visible interpersonal skills and the educational capacity to lead effective Board meetings and maintain credibility with the health staff and Chief and Council.

The authority and accountability of the Board was structured around the legal framework and specific duties, powers, responsibilities and accountabilities required of board members in the Non Profit Corporations Act with specifics identified in the corporation's bylaws. The Board had the authority to create bylaws with respect to internal matters such as the structure of the organization and terms of election but these were subject to the approval of the Chief and Council as members who had a duty to ensure that the band membership was getting the health services identified under the terms of the health transfer agreement. The standard of care required by the Board in discharging their duties was to act honestly and in good faith for the best interests of the organization and to exercise the due diligence, care and skill required of a reasonable person in comparable circumstances.<sup>11</sup>

A system of checks and balances on Board authority against potential misuse or abuse of power associated with the official standing was also provided. Although the authority of the Board covered the entire management of the organization, it was limited to policy functions with the day-to-day operational duties assigned to employees. While the Board was recognized as the "controlling mind and policy makers of the corporation," they did not have the responsibility or duty for "day to

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<sup>11</sup> Nahachewsky, Carl M., legal counsel for PBCN Health, in a document entitled, Peter Ballantyne Cree Nation Health Services Inc., Executive Summary, PBCN Health Services Inc., September 17, 1998, 1

day operations of case loads, " which were staff and employee functions.<sup>12</sup> There were also conflict of interest provisions that required that individual Board members would remove themselves and not vote in cases where they had a perception that they could get personal gain, either monetarily or in some other way.

Practically, Board governance was through a blend of formal and informal collective deliberation based on group rather than individual decision-making. Their role and the roles of the other key players were formalized in organizational policies and procedures that were developed through a similar form of collective deliberation. The structural inclusiveness of the involvement of Chief and Council and the community in the formal policy and decision-making processes of the organization was based on a desire by the Board to 'work together' with the other players towards a common agenda rather than struggling or competing with them. The Community played an advisory role to the Board and management through organized local health committees, interagency groups, and elders and youth forums and on an individual basis. The formalization helped to demonstrate the Board's commitment to inclusion rather than exclusion and because it was visible, made it more credible to the other players. In their relations with Chief and Council for example, even in the face of disagreements with particular Health Portfolio Councilors, the decisions of the Board prevailed. This was an example of how the distributed authority in the form of administrative authority was devolved from the Chief and Council to the Board. There was never any question that the Chief and Council retained political authority, but they could not by their own mandate under the Agreement and their participation in the development of governing policies, interfere in the daily management of the

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<sup>12</sup> *ibid*, 2

organization. This was partly reflective of the Chief and Council's initial political support for the Board and the trust the Board gained by keeping the Council informed and involved in the decision-making. MSB officials played more of a technical advisory, monitoring and negotiating role to the management staff whenever it was required.

The policy route also formed the basis of the internal Board relationship with the health administration. The policies and procedures required certain standards of behavior for both the Board and employees. In dealings with personnel issues, the Board had delegated authority to managers to implement the policies and even in cases where individual Board members may have disagreed with management decisions (usually discipline related) and raised their concerns at the Board meetings, the Board's position was that as long as proper procedures were followed, management decisions prevailed. This was also the case where policy guidelines may have been too flexible and unclear in certain areas such as the conflict of interest and confidentiality provisions. This delegated administrative authority allowed the managers and staff to do their work with minimum direction (arms length) from the Board in day-to-day issues and provided them with a certain amount of security to do their work without fearing political repercussions from any of the Board members. Conversely, this management authority was not without conditions. The required accountability of managers to the Board was to keep them fully informed by regular program and financial reporting and to demonstrate visible successes such as balanced budgets and program enhancements. Management confidence was an



important factor in maintaining Board confidence in the policy process and influencing Board decisions.

In coordinating all these internal and external relationships with the key players, the Board's commitment to abide by the policy route was crucial because it formed a common standard for all players in health thereby implying neutrality and objectivity. The PB Health policies and other respective program and strategic directional plans were based on the general guidelines of the Community Health Plan which was essentially a 'map' of general guidelines for the Board and organization to follow as part of Transfer and not following these policies would have diverted from the original plan and possibly led to many non-compliance problems. Essentially, the Board's commitment to the formal structure of organization, especially in the face of personal and political decisions, was largely sustained by both the security associated with group decision-making and the awareness that they as individual Board members were also responsible for the corporate decisions of the Board. The constant reminders for more local control and better quality of health services in community meetings also helped maintain a high level of political awareness among the Board members of the people's needs and reminded them of the vision and purposes behind the Transfer.

#### **Comments on the Governance Approach**

The governance approach is generally more concerned with processes and the "pattern of authority within which decisions are made regarding fundamental activities,"<sup>13</sup> or as others put it, the "art of steering societies and organizations."<sup>14</sup> It is

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<sup>13</sup> Brodie Janine, Sandra Rein, eds., Critical Concepts: An Introduction to Politics, Third Edition, Toronto, Ontario: Pearson Prentice Hall, 2005, 80

usually used in the context of explaining the broader State-society relations, but it can be applied to any form of collective action. It is also used in explaining changes to State-First Nation relations; particularly those associated with the distribution of power brought about by the devolution of government programs to First Nations, such as health transfers. The integrated approach was applied to the PB case because of the obvious interdependent relationships and interactions of the key players in the Agreement.<sup>15</sup> The integrated approach acknowledges the strong relationship and reciprocal influences between the State government and other governing authorities like boards and corporations. It examines their interactions and participation in the governing processes. It recognizes that these relationships are imbued with issues of power and authority and accountability that have to be considered. Since relationships were a key theme in governance it was important to understand how the Board managed their relationships with the other key players involved in health such as the PB Chief and Council, MSB, the community, health staff and other affiliated agencies.

Political culture was another key theme. There was an assumption that Board governance in the northern PB communities would be different from Board governance in the broader society because of the more integrated, smaller and closely related populations and their kinship oriented political cultures. Board members in this environment require not only local knowledge and interest, but also a certain

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<sup>14</sup> Institute on Governance, in collaboration with York University, CESO Aboriginal Services, Saskatchewan Federated Indian College, Understanding Governance in Strong Aboriginal Communities. Phase One: Principles and Practices From the Literature, October 12, 1999, ii, (<http://www.iog.ca/publications/strong-ab-gov.pdf>)

<sup>15</sup> Pierre Jon, editor, Debating Governance: Authority, Steering and Democracy, Oxford University Press, New York: 2000, 162 from article by Jan Kooiman entitled, "Societal Governance: Levels, Modes, and Orders of Social-Political Interaction."

blend of negotiation and organization skills. Board governance can be likened to commercial fishing in the north where, among the many skills required, steering a boat and working in bad weather are fundamental. Skillful fishermen know how to negotiate, not fight, the waves to get to where their nets are located in order to check them. So it was with the Board, the more they worked together as a group engaged in a common purpose, the more they learned to negotiate rather than struggle against the other players who also had certain rights and power in the governing of PB health.

It was also important to consider the scope and type of power and resources that the Board had under the Transfer Agreement. Generally, Health Transfers were administrative instruments for transferring management and program control to First Nations and were part of MSB administrative reforms and devolution policies. There are many perspectives on the costs and benefits associated with devolution in the broader governance literature, but the more contrasting ones are the State-society views and others fall somewhere in between. All perspectives agree that the role of government institutions has changed from direct management of public services to a less direct monitoring and facilitating role. This was the largely the case in the PB Health experience. The role of the State (MSB) did become more hands-off than before in terms of program implementation. In their interactions with PB Health, MSB officials generally operated in an informal fashion providing consultation and assistance when requested, but they did play more of a direct monitoring role in ensuring that the financial and program reporting requirements of the Agreement were being met.



Society scholars such as Jon Pierre support a minimalist State and portray devolution policies as effective institutional mechanisms for enhancing citizen participation and self-governance. They see such policies demonstrating the State's ability to adapt or transform itself to accommodate changes in its external environment.<sup>16</sup> In this environment, the role of government changes to a more coordinating and facilitation function manifested by the creation of policy relationships and partnerships. State scholars, on the other hand, worry about the potential "withering away" of the power and capacity of the central government institutions to protect the collective interest and to maintain their 'steering' role.<sup>17</sup> Others like Kooiman take more of an integrated perspective acknowledging the interdependent and mutually influential relationships between the realms of the social and political or between the state and civil society thereby advocating that their interactions be studied together.<sup>18</sup>

This case study favors the integrated perspective blending the state-centric<sup>19</sup> and society-centered views as a way of acknowledging the emerging stronger role of community authorities in broader Band governance. According to the integrated perspective, both the State and the First Nation governments are portrayed as going

<sup>16</sup> Leo Panitch on civic society has influence, Paul Sabatier (1988) Michael Howlett, Jeremy Rayner on Advocacy and Policy Networks, (1988), scholarship on new social movements such as social feminism, Sandra Burt (1990), Sally Weaver (1993), J. Brodie (1985) etc. and Aboriginal politics, Robert Depew (1994). Frank Cassidy, Robert L. Bish (1989), Alan Cairns (2000) Peter. D Elias (1991), Linda T. Smith (1999), Evelyn J. Peters (1986).

<sup>17</sup> Pierre Jon, Ed., *Debating Governance: Authority, Steering and Democracy*, New York: Oxford University Press Inc., 2000, 4

<sup>18</sup> Pierre Jon, editor, *Debating Governance: Authority, Steering and Democracy*, Oxford University Press, New York: 2000, 162 from article by Jan Kooiman entitled, "Societal Governance: Levels, Modes, and Orders of Social-Political Interaction."

<sup>19</sup> Theda Skocpol, Kenneth Finegold (1982), Charles Lindblom (1982), Peter Gourevitch, E.H. Fry (1998), Gilles Paquet, David Hayne (2000), Ken Kernaghan (1995), Peter Drucker (1995), Judith Gruber (1988), H.H. Gerth and C. Wright Mills in "From Max Weber," (1946), Mark Turner, D. Hulme (1997), Gilles Paquet, D. Hayne (2000), and A. Cairns, (2000)

through a period of transformation, not decline, and both are adapting and negotiating new relationships and roles in their quest towards a common public good. The impact of MSB devolution policies devolving health services to 276 /599 or 46% First Nation communities across Canada is visibly changing the way health is being delivered on reserves. The role of MSB (State) is changing from direct delivery to more of coordination and monitoring of Agreements, especially following the concerns with fiscal accountability in the Auditor General's Report in October 2000.

<sup>20</sup> This change in role was evident in the PB situation. In the first year, the contact between the MSB and PB Health officials was more extensive than the other years, but became less so as the organization grew and stabilized. The Board-MSB interactions were mostly limited to official meetings and visits regarding issues relating to the Agreement and negotiations for new programs

The way the PB Agreement was structured ensured the continuing significance of MSB and the PB Band government in health services, albeit it did change their respective roles from direct management and delivery to more of a consultative and monitoring role. The most visible residual role of MSB was associated with being a primary funding source and having continuing federal responsibility over health matters on reserve. The most visible role of the Chief and Council was associated with their overall political authority over all reserve matters including health. The Board's role was to manage the Agreement on behalf of the Band, and as part of that administrative responsibility, the Board had to work out an effective working relationship with both parties. While the personal credibility of the

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<sup>20</sup> First Nations & Inuit Health Branch, Annual Report, First Nations & Inuit Control, 2000-2001, Ottawa: Health Canada, 2001, 2, 3

Board and management were important factors, what became more important (because of periodic changes to the Board, Portfolio Councilors, and management) was to structure the organization relationships through a formal system of Board-approved policies and procedures. The personnel and administration policies and rules basically provided a standardized management mechanism for coordinating internal and external relationships, and while these could be amended on an annual basis, the practices remained consistent regardless of who was on the Board or Chief and Council. In this sense, there was much administrative autonomy for the Board.

### **Power and Authority**

In relation to the larger concerns expressed by State scholars over the "withering away" of the State because of devolution, the transfer to the PB Board did take away a certain amount of administrative autonomy and financial control in the case of the Band, but it would be an exaggeration to suggest it diminished or "withered" the political role and power of either the Band or MSB over health matters. Both supported the Board governance and policy processes and while individual Band Councilors may have disagreed with Board decisions from time to time, there was enough commitment by all parties to adapt to the new relationship. The 'buy-in' was first a political decision by Chief and Council to go the Board route, and later it became one of proven credibility where problems were visibly resolved with less conflict when done through standardized processes and structured relationships rather than personal feelings. In this sense, this could be said to reflect what society scholars might have meant in portraying devolution as a positive response by the State to "adapt" or "transform" to environmental changes. In this



case, the Transfer was a positive State response to the political desire by PBCN to control their health services and the State's continuing role in PB Health suggests that it was certainly not withering away – just changing functions in a limited sense.

While Transfers, such as PB Health, may operate under the broader shadow of the historical, Constitutional and Treaty relations between the State and First Nations, they clearly remain administrative instruments. Devolution is an administrative mechanism for addressing First Nation demands for self-government within a limited scope of authority. This was evident in the policy position of the federal government where they made it clear that the Indian Health Policy and Transfers to First Nations are administrative transfers based on historical policy considerations of their “special relationship” with Indian people, rather than the recognition of the “treaty right” to health.<sup>21</sup> While the PBCN Chief and Council understood the federal position, they still insisted upon including Treaty protection clauses in the Transfer Agreement to prevent any interpretation of a potential settlement of their Treaty rights to health. Consequently, the PB Transfer Agreement is prefaced with 3 pages of Treaty protection clauses in relation to Treaty #6 to which PBCN adhered to and which is the only Treaty with a “medicine chest clause” which PBCN and other First Nations have interpreted as a Constitutional obligation by the federal government to provide “accessibility and availability “ of ongoing full medical services and benefits.<sup>22</sup> This is not to say that other Treaty avenues are not being explored. Currently, Health

<sup>21</sup> Minister of Health, Health Canada, *Ten Years of Health Transfer: First Nation and Inuit Control*, Ottawa: Minister of Public Works and Government Services Canada, 1999, 2

<sup>22</sup> The Minister of National Health and Welfare, The Peter Ballantyne Band, The PBCN Health Services Inc., *The Health Service Transfer Agreement, 1995*, Prince Albert, Sask.: 1995, 1-3; also, The Royal Commission on Aboriginal Affairs, *Treaty Right to Health: A Discussion Paper for The Royal Commission On Aboriginal Affairs, February, 1993*, Ottawa: RCOAP, 1993, 2

Canada is involved with the Federation of Saskatchewan Indian Nations and others in trying to work out "self-government" arrangements and new fiscal and governance relationships "based on the Treaty relationship" through a variety of "exploratory Tables."<sup>23</sup>

The integrated perspective also has certain assumptions about devolution and good governance. It assumes that devolution will lead to good governance because it allows for a better distribution of certain government powers and authority among the different groups in society and provides more opportunities for local socio-economic empowerment. It allows individual citizens to have more direct input in the governing and delivery of public services through their involvement with non-government service organizations. It further assumes that citizens and groups in society have the capacity and can articulate and address their own needs better than government. It anticipates that societal governance will more likely develop institutions that are more community responsive, caring and less hierarchical. It suggests that management practices will be characterized by team-building policies rather than authoritarianism. There will be a more visible outreach to the community through partnerships and enhanced programs and services. It implies that governing decisions by community boards will be based on consensus and be more transparent and publicly accountable.

The PB health model appeared to support some of these assumptions. The Board because they were not politicians had more time to spend on health matters and to focus on structural organizational issues. They developed a specialized knowledge and awareness of community and regional health issues and were able to influence

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<sup>23</sup> First Nations & Inuit Health Branch, Annual Report, First Nations & Inuit Control, 2000-2001, Ottawa: Health Canada, 2001, 2

the political agenda to some extent through the combined work of the Portfolio Councilors, local Board members and health committees. The Board's approach to governance was to relate to the community and others by integrating and outlining their roles and functions in the organization policies and procedures. This policy approach is indicative of the Board's adaptive strategy to minimize political concerns over the perceived loss of Chief and Council power over health matters. While the Board may have been given administrative authority over health funding and services, it did not transfer political power. The reporting line to the Chief and Council made the Board's accountability to them evident. Although there were often timeliness problems associated with documentation and other requirements, the idea that processes had to be followed when making decisions resulted in less crisis management situations and less reliance on verbal reports and rumor.

It was evident that the success of the Board was dependent upon keeping the other key players informed about their activities through regular reporting and keeping them involved in decision-making functions and in the development of policies and program work plans. The Board and political leadership continuously attributed any successes to "working together" in their meetings and annual reports. For example, in 1999, the Board Chair recognized the Chief and Band Councilors for their "great support" and the Chief likewise assured the membership of his confidence that "we will continue to have professional health services delivered through the life of this Agreement."<sup>24</sup> In 2000, the Board Chair stated the goals of the Agreement were met and the Agreement renewed because of the Board, staff and Chief and

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<sup>24</sup> PBCN Health Services Inc., *PBCN Health Services Inc., 1995-1996 Annual Report*, Prince Albert, Sask.: PBCN Health Services Inc., 4-5



Council "working together," and the Chief's message showed the continuing political commitment of the Chief and Council to "work with everyone to build our health system."<sup>25</sup>

It was also evident that the Board needed this support by the key players in order for the management to properly implement the organization policies and procedures. The Board members themselves sometimes had difficulty in being able to separate their political and private interests, and in these instances, the fact that they could make not make decisions by themselves without going to the full Board triggered process rather than impulsive decision-making. The other key players such as the Chief and Council supported the policy approach taken by the Board largely due to the support and advocacy of the Portfolio Councilors who represented the interests of the Chief and Council on the Board in an ex-officio, non-voting capacity. With the inclusion of the Portfolio Councilors in the decision-making processes, the Board created an efficient way of keeping the Chief and Council informed and supportive of organizational decisions. The benefit to Chief and Council in having the day-to-day problems delegated to managers and health staff was the removal of small "p" politics associated with financial and personnel issues.

MSB support for the policy approach to governance was clearly evident in the Transfer requirements for policies and procedure manuals, but the relationship was flexible in terms of administration methods. Aside from dealing with the service and financial requirements of the Transfer and new issues arising from TLE and other community needs, the interaction between the Board and MSB was minimal. With

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<sup>25</sup> PBCN Health Services Inc., PBCN Health Services Inc., 1995-1996 Annual Report, Prince Albert, Sask.: PBCN Health Services Inc., 4-6

respect to support from local health staff and community health committees, this was demonstrated in the positive feedback given at the various staff conferences, even though there were some criticisms of the Board being "too business like" in their approach to health care management. Nevertheless, the overall general support by the key players, especially Chief and Council, was an important reinforcement of the Board's policy approach to governance and their inclusive strategies in policy development and decision making.

Although policy channels were often time consuming and restraining in practice, the Board chose to err on the side of caution in order to prevent the making of arbitrary decisions which could lead them into legal liability issues. As a corporate Board, each of them could be personally liable for wrongful decisions, which was not the case for the other key players, except in cases of criminal acts and medical negligence. This personal liability issue was perhaps one of the more important determinants for the Board's adherence to the policy processes. The policy channels helped create a decision-making structure for coordinating relationships and managing behaviors, and it also gave a certain amount of job security for health staff which could account in part to the successful staff retention and recruitment reports described in the PB Health annual reports.

### **Accountability**

The PB Board accountability was technically an administrative one in the Transfer Agreement. The Transfer set out the financial and program obligations with

the implementation process outlined in the PB Community Health Plan. According to the funding agency, MSB, accountability was defined as "the obligation to take and demonstrate responsibility for performance based on agreed expectations and within the limits of budgets and existing authorities."<sup>1</sup> In terms of political accountability to the PBCN members and Chief and Council, the Board was responsible for the effective management and delivery of health resources to meet community health needs. The primary mechanisms for ensuring accountability included the requirement for annual comprehensive financial and performance audits and annual reports submitted both to MSB, the Chief and Council, and to the community membership within 90 days of the fiscal year end.<sup>1</sup> Other requirements had to do with implementing policy documents such as the Personnel and Operation manuals, the emergency response plan, and evaluation plan.

As in other corporate organizations, the Board had overall legal authority and accountability for PB Health, but it relied mostly on the administration to exercise this authority and to fulfill its accountability. This dependence on others to make decisions on their behalf and the potential liability attached to individual Board members provided a strong incentive for the Board to ensure that the managers were fully informing them on major decisions and following policy guidelines when making decisions. For example, the managers at the central and community levels were required to provide monthly financial and program reports at the Board meetings and to present health reports to the community members at regular community meetings and at Chief and Council meetings. In addition to these formal accountability mechanisms, management accountability to the Board was also



informal. It was common practice for Board members to raise issues they considered urgent to the Executive Director in between Board meetings, and if a Board decision was considered essential, a conference call was usually convened.

The potential liability attached to each of the Board members for decisions made, especially for financial ones, also had some influence in supporting Board discipline to follow policies rather than being forced to make political decisions contrary to the Agreement. For example, the periodic requests by Chief and Council to contribute a certain portion of the management funds to the central Band administration were resolved through clear provisions in the Transfer Agreement stipulating that Transfer funds be not transferred "to any other Band program or for other Band operations."<sup>1</sup> The Board used these provisions in their letters to the Chief and Council administration as reasons for not complying with the requests. In their discussions, the Board was sensitive to the fact that they, not the Chief and Council or anyone else, had the personal liability attached to them for managing the Agreement and consequently wanted to avoid potential problems.

Aside from formal accountability, there was also the political reality of Band members demanding more accountability from Band agencies like PB Health, although it was unclear what this entailed. The PB Board interpreted it to mean more public meetings, better responsiveness to community concerns, more local control and community input in policy and planning through health committees, organized interagency networks, and other means of organized support groups. The Board's accountability to MSB as a funding agency was clearer with strict requirements for fiscal and program reporting.

Although most scholars recognize that a universal model of aboriginal governance does not exist among the First Nations, due to each having its own distinct ways of steering its society and institutions,<sup>26</sup> there is an assumption that because they are from traditional societies, they will develop similar forms of participatory governance in varying degrees such as the practice of consensus decision making, elders advice and being accountable through open public meetings. There is a tendency to believe that the past accountability practices were somehow better than the present, that traditional leaders led more by consensus and were more caring, and for things to get better, these systems have to somehow be restored. The Royal Commission of Aboriginal People's report, for example, concluded that community healing was a prerequisite for self-government. There is some merit to this notion because of the strong influence of families in both traditional and contemporary societies. While family influences are by no means unique to First Nations, they are not as marginalized and separated from the political systems on reserves as they are in the larger society. Populations are small, everyone is related in one way or another and because of the lack of economic and other opportunities, and the Band government has greater influence over people's lives through its access and control of government funding. With the replacement of traditional systems with Band systems and the other related modernization changes, family systems have also changed and may not necessarily be the most appropriate or practical vehicles for choosing leadership and equitably distributing Band resources today. Some

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<sup>26</sup> Mercredi Ovide, Turpel Mary Ellen, 1994; Frank Cassidy, Robert Bish, 1989; Jill Oakes, Rick Riewe, et al., 2001; Wayne Warry, 1998; Robert Depew, 1994; Tim Plumptre and John Graham, Dec 3, 1999; John H. Hylton (ed) 1994; Menno Boldt, 1993; Yngve Georg Lithman (1984)

formalization through institutional building is being favored as a means of objectifying decision making and keeping personal 'politics' out of local governance.

Such is the case with PBCN. Structurally, the PBCN Band administration is centralized in Prince Albert and Pelican Narrows, although the other communities such as Deschambault Lake and Southend manage many of their own programs. PB Health followed a similar regional pattern of governance with Board members and Portfolio Councilors from each of the communities politically representing their membership at Board meetings. The presence of Portfolio Councilors at Board meetings was a reminder of the greater political power that the Chief and Council had over the administration authority of the Board. While they may have been intimidated to some degree, the Board generally had positive experiences in working with the various Portfolio Councilors. Although operational issues were often raised and discussed at Board meetings, particularly in the first year of Transfer, the Board's response was to refer to policy and delegate the matters back to management and request that they be kept fully informed and assured that proper documentation and processes were being followed.

### **Relationships**

The Transfer forged new relationships in health governance for PBCN. Normally with Health Transfers, Band or Tribal Council administrations manage the funding and deliver the services through bilateral agreements between the Chief and Council and MSB. In the PB Transfer, the inclusion of the Board was unique because it separated the political and administrative authority of the Chief and Council giving administrative and financial control to the Board, but there was no precedent to show



how this was going to work out. The Board essentially formalized their relationships with the Chief and Council and MSB, as well as their internal (staff) and external relations with the community and other agencies. The Board delegated management authority to its managers and staff and concentrated on policymaking and the larger decisions. Standard personnel and administration policies and rules became the new precedent for the management and governance of PB relationships with the other key players. Interactions with MSB and Chief and Council were limited to supporting and monitoring functions, rather than direct management and service delivery.

Nevertheless, Chief and Council influence was stronger and more frequent than the supporting and monitoring functions of MSB with the representation by the Portfolio Councilors at the regional Board and local health committees as well as the regular reporting at Chief and Council meetings. It was also accepted political protocol that the Chief and Portfolio Councilors lead any negotiations with senior MSB officials with administrative support from the Board and management of PB Health.

Community input was largely done through individual access to Board members and through the health committees and various other participatory mechanisms such as interagency groups, elders and other public forums. Community complaints were streamlined and resolved through official channels and if the complaints were timely, posed no problems, but if the complaints were raised way past the time of the alleged incident then the complaints were harder to resolve and created more frustration.

Although the Board desired a professionally structured and neutral organization, they also wanted a more caring organization where Band members could feel comfortable in accessing services. One strategy was to maximize local

employment and training and minimize external management. The assumption was that local people would make better and more stable employees because they spoke the Cree language, knew the people, and lived in the communities and would likely stay longer than those from the outside. There was a concerted effort to keep the regional management staff small and focused on training and consulting support rather than direct supervision. The success of the employment strategy was evident in the 2000 employment records of the PB organization where 77% of the 84 staff were made up of Band members with management size consistent at 16 managers.

The Board knew in the beginning that it was neither possible nor practical to completely separate politics from administration because everyone was so inter-related in the communities and were in daily contact with each other on personal and professional levels. To deal with potential conflicts, the Board provided conflict of interest guidelines in their hiring policies and voting procedures. Although bias is difficult to prove and prevent, policy guidelines were the Board's best efforts. The main line for Board members, health committees or staff removing themselves from certain decisions was in those cases involving immediate family members or those to whom they felt were too close. The fusion of both the personal (family) and public (Board, committees) elements in this regard produced operational guidelines that were different from the broader society where kinship relations at any civil service level are interpreted as being potential biased and subject to patronage.

This policy route in governance and the persistence of the Board and management in managing relationships and services through common standards and guidelines provided a fairly stable environment within the organization. One of the

tests that arose during the 5 years of operation was during Band elections and whether changes to Chief and Council would negatively impact PB Health. They did not.

Organizational support by Chief and Council remained strong throughout. While this could be attributed to many things, Board policy was a contributing factor because it kept health away from the political arena. PB employees were required to show respect and neutrality in their work and to refrain from getting personally involved in local politics while they were employed unless they took a leave of absence to run in local elections. The Code of Ethics clearly stated that employees were to respect political authority and to refrain from public criticism of anyone whether it was the political leadership, the Board and other community members. While this might seem like a standard requirement in larger society, it was not so in the PB communities because everyone was related and tended to be pulled in to electoral politics just by association. Therefore, for employees and Board members to remain officially neutral and to protect confidentiality in such settings took a mix of personal and public effort. There was no similar policy precedent in the PB Band administration system, which might have given PB Health an added profile as an alternative arms length organization.

### **Political culture**

Political culture is about shared political values and belief systems. Band history is of political value for most PB Band members and leadership. References to Band history and Treaty affiliations are in most of the PB Health documents and often mentioned in Board meetings around discussions dealing with the mission and purpose of Transfer. Most Board members were familiar with the oral and



documented PBCN history of their ancestors consisting of scattered and nomadic hunting, fishing and trapping Woodland Cree societies<sup>27</sup> consisting of closely related family households.<sup>28</sup> They also knew things had changed and with all the changes associated with modernization and population growth, PBCN had become one of the ten largest Bands in Canada<sup>29</sup> with eight communities combining a membership of over 7300 people,<sup>30</sup> over half residing in the reserve communities. While the exact genealogy of the first Chief, Peter Ballendine (now Ballantyne) remains uncertain, most Band members in the communities have some relational link and consider his signing of the adhesion to Treaty #6 on September 3, 1878 as a fundamental turning point in their history. The settlements associated with the outstanding land claims from this Treaty, for example, expanded the PBCN territory to include much of the northeastern and north-central part of Saskatchewan, 454 km north of Prince Albert and 508 km east to the Flin Flon, Manitoba border.<sup>31</sup>

According to historical assumptions of northern traditional life, the communal and highly personalized approach to health care in the past through family social units

<sup>27</sup> Brightman Robert E., *Grateful Prey: Rock Cree Human-Animal Relationships*, Berkeley and Los Angeles, California: University of California Press, 1993 quoting James G.E. Smith., 1981. "Western Woods Cree" in J. Helm, ed., *Handbook of North American Indians* Vol. 6, Subarctic. Washington D.C.: Smithsonian Institution

<sup>28</sup> Buckley, Helen and Kew J., Hawley John, *The Indians and Metis of Northern Saskatchewan: A Report on Economic and Social Development*, Saskatoon: Center for Community Studies, 1963; also, Ballantyne Phillip, et.al. *Aski-Puko: The Land Alone*, Saskatoon: Office of the Treaty Commissioner, 1976

<sup>29</sup> Information Management Branch, Department of Indian Affairs and Northern Development, *Registered Indian Population By Sex and Residence 2000*, Ottawa: Minister of Public Works and Government Services Canada, 2001

<sup>30</sup> Prince Albert Tribal Council data on PBCN's registered population as of August 2003. Website: [http://sdiprod2.inac.gc.ca/FNProfiles\\_GeneralInformation.asp?BAND\\_NUMBE....](http://sdiprod2.inac.gc.ca/FNProfiles_GeneralInformation.asp?BAND_NUMBE....), note: Population statistics vary; according to the Indian Affairs 2000 Registered Indian Population, PBCN is listed at 6901; and as of 2004, 7460

<sup>31</sup> PBCN Health Services Inc., *Home and Community Care Service Delivery Plan, May 2001*, Prince Albert, Saskatchewan, 2001, 5.

or households usually headed by male patriarchs or fathers<sup>32</sup> was not isolated to healing, but could be found in all aspects of their traditional way of life. This is evidenced by some of the descriptive terms used such as communal, consensus decision-making and direct citizen involvement,<sup>33</sup> extended kinship groups,<sup>34</sup> collective ownership, equal access,<sup>35</sup> sharing among family households, kindness, assistance, cooperation, respect, hospitality,<sup>36</sup> among others. Some further suggest that in spite of the many changes and colonial influences, these values of spirituality, respect, self-reliance, cooperation, sharing, generosity and hospitality continue to some degree in First Nation communities.<sup>37</sup>

The degree to which traditional systems influenced the PB Board is uncertain. It is easier to assume that the decision making in the past was flexible and largely directed by group consensus because it would have been considerably easier for small households living alone in remote trap lines to communicate daily than it is today with family households having separate incomes and being centralized into organized

<sup>32</sup> See Chapter 3 of thesis. Also, Buckley, Helen and J. Kew, John Hawley, The Indians and Metis of Northern Saskatchewan: A Report on Economic and Social Development, Saskatoon, Sask.: Centre for Community Studies, 1963; also, Ballantyne Phillip, et.al., Aski-Puko: The Land Alone. A Response to the Proposed Hydro-Electric Installation at Wintego Rapids by The Cree of Peter Ballantyne and Lac La Ronge Bands, Saskatoon, Sask.: Office of the Treaty Commissioner, 1976; also Brightman Robert, Grateful Prey: Rock Cree Human-Animal Relationships, Berkeley and Los Angeles, California: University of California Press, 1993.

<sup>33</sup> Cassidy Frank, Robert L. Bish, Indian Government: Its Meaning in Practice, Lantzville, B.C. Canada: Oolichan Books and the Institute for Research on Public Policy, 1989, 77-78;

<sup>34</sup> Boldt Menno, Surviving as Indians: The Challenge of Self-Government, Toronto: University of Toronto Press, 1993, 118-119

<sup>35</sup> Leacock Eleanor and Richard Lee., Politics and History in Band Societies, Cambridge University Press, 1982, 8-9

<sup>36</sup> Ballantyne Phillip, et.al., Aski-Puko: the Land Alone, Saskatoon: Office of the Treaty Commissioner, 1976, 5-6; also, Ron Merasty, A Portrait of the Peter Ballantyne Cree Nation, in "Traditional Cree Culture, Part 2: Cree Cultural Traits, Prince Albert, Sask.: , unpublished historical writings, 9; also in Robert Brightman E., Grateful Prey: Rock Cree Human-Animal Relationships, Berkeley and Los Angeles, California: University of California Press, 1993, 10; also Helen Buckley and J. Kew, John Hawley, The Indians and Metis of Northern Saskatchewan: A Report on Economic and Social Development, Saskatoon, Sask.: Center for Community Studies, 1963, pg

<sup>37</sup> Young T. Kue, Health Care and Cultural Change: The Indian Experience in the Central Subarctic, Toronto: University of Toronto Press, 1988, 14

communities separated by zoning divisions and other municipal infrastructures. While families may not be as close today, most are connected by a common political identity based upon Band affiliation and community membership. It was evident by the PB planning documents and Board reports that families and kinship relationships were an important part of this political identity. The focus of Transfer itself was to build healthy families and healthy communities. Even with respect to political power, family numbers continue to determine community leadership during elections with leaders (usually male) coming from large families, but this too is changing with more women running in local elections and getting involved in local Boards and committees. Women for example, dominate the PB Health Board, although this too is slowly changing with men getting more involved in social and health programming.

In the PB organization, Elders, both male and female, were integrated into the formal organizational structure to provide advice and support to the Board and community health committees as well as to the management at all levels. This protocol was consistent with the Chief and Council practice of having elders present at meetings and being involved in key decisions and various appeal boards, and it is generally expected of most PBCN affiliated agencies to do likewise. While the Chief and Council maintained a strong political influence over most of community life, Band members also had a strong political voice. The various pre Transfer and post Transfer surveys imply that it was part of the political culture for people to expect Chief and Council to personally help them during times of need and if they did not feel helped, their views towards Chief and Council and the Board as well tended to be more critical. The Board experienced many such personal demands during its tenure



and learned early that governing and management through structured processes and policy guidelines helped to better control crisis management situations although in the short term, it may have seemed less timely.

The spiritual beliefs of the community people were also important cultural factors to be aware of especially with the political expectation to design and deliver culturally appropriate services. The majority of PBCN members had Christian-based beliefs through affiliations with the Roman Catholic, Anglican and other churches, but there were also those who preferred Indian spirituality. It was important to be aware of these differences especially when there was no agreement as to what "culturally appropriate" meant. Historically, traditional medical treatment was provided through the families by shaman or recognized healers, but that changed with modernization, and was largely replaced by Christianity and western medicine. Although the majority depends on western medicine for healing, many have considered alternative ways including herbal treatments.

One of the quandaries that PB Board faced was whether to facilitate spiritual practices within the health centers particularly when there was no consensus around which could be considered appropriate spiritual practices. The new MSB buildings, like the one in Pelican Narrows, had been designed with a special room designed for ceremonies, however, because of the history and culture of the communities where healing practices were personalized rather than institutionalized, the room was not frequently used. The Board believed that spirituality was ultimately a private matter and choice and not the business of the health centers. Therefore they felt that their main responsibility was to make sure that the health centers were providing the

required mandatory medical services and programs as comprehensively as possible for all the people in the communities. The potential legal liabilities associated with medical service delivery were also determining factors in the Board's preference to provide western-based medicine rather than alternative medicine. There were situations where people substituted prescribed medicines with alternative medicines and got into life threatening situations. To offset potential lawsuits for such cases, the Board had to ensure that the management staff had procedures in place that required patients to sign consent forms indicating they were choosing alternative treatments.

All of these suggest that PB political culture has elements of both traditional and non-traditional values and worldviews. The traditional values around family, caring, respect and economic well being guided by a holistic worldview and informal decision making systems were integrated with contemporary values associated with public governance such as fiscal accountability, participation, equity and technical capacity, most of which are associated with the institutionalization of policy and decision making. The pre-Transfer surveys reflected the desire of the communities for better quality medical services that combined a wide array of support programs focused on physical, mental, emotional and spiritual well being to help develop safer environments for individuals and families. The PBCN Community Health Plan described this holistic view towards health in terms of "a general state of total well-being and effective functioning rather than just an absence of physical illness."<sup>38</sup> The primary goal was to build a sustainable community-based health system based on

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<sup>38</sup> PBCN, PBCN Community Health Care Plan, January 1995, Pelican Narrows, Sask.: 1995, 9

values of "balance, of wholeness, of optimum well-being and of the realization of all of one's potentialities."<sup>39</sup> The guiding principles or values of the organization were:

1. That Indian people must have equal access to health services of the same range and quality as is available to the rest of the province.
2. That PBCN Health Services must incorporate the holistic approach to meet the individual, family and communities' spiritual, cultural and social needs;
3. That cooperation with other health delivery systems shall be ongoing on an equitable basis for the benefit of all;
4. That it is the right of Indian people to determine their own needs and to design and control a health delivery system to meet their needs."<sup>40</sup>

The purpose or mission statement was:

"To provide and facilitate a wholistic health service that promoted physical, mental, emotional and spiritual wellness to its members in the communities of Pelican Narrows, Deschambault Lake, Southend and Sturgeon Landing."<sup>41</sup>

The concept of what was meant by these holistic services was defined at an earlier orientation conference, where during the course of the discussions, a picture of a calm northern lake with trees and hills was used as a metaphor for what the Board desired their communities to look like – peaceful and safe – just like they used to be before all the problems associated with alcohol and drug abuse dominated their lives.<sup>42</sup> In other words, PBCN Health was expected to help people deal with these problems in their communities by developing a wide range of health services from the

<sup>39</sup> PBCN, *The PBCN Community Health Care Plan*, Pelican Narrows, Sask.: January 1995, 7

<sup>40</sup> PBCN Health Services Inc., *Directional Plan*, Prince Albert, Sask.: PBCN Health Services Inc., 7

<sup>41</sup> PBCN Health Services Inc., *Directional Plan*, Prince Albert, Sask.: PBCN Health Services Inc., 4

<sup>42</sup> PBCN Health Services Inc., *Transfer of Health Services*, Presentation paper, PBCN Health Services Inc., Prince Albert, Sask.: 1999; and from my own personal notes from that conference.



24-hour, year round medical treatment services, health education, counseling and other addiction support services which were required by the Transfer Agreement and to expand beyond these to develop new projects and programs designed to support and help individuals, children, youth, elders and families improve their quality of life within safe environments.

### Conclusions

Scholars suggest that institutional and governance developments on reserves are more than just service delivery mechanisms, they reflect the "emerging nature of Indian government in practice: while seeking a change in the basic design of Canadian federalism, Indian peoples and their governments have taken advantage of the possibilities in the current federal-provincial framework to realize and extend their vision of Indian government."<sup>43</sup> It is suggested that case studies such as the PB case will not only "open new intellectual space,"<sup>44</sup> for scholars to examine how First Nation governments influence or are influenced by government policies, they will also help inform developing works in First Nation governance. Aside from specific management experiences, some useful conclusions that emerged from the Board's overall experiences can be summarized as follows:

1. That the government devolution of public programs like health to First Nations control are important mechanisms for local control, community development and enhancement towards self-government.
2. That community corporate Boards and organizations acting at an arms length from Chief and Council, like PB Health, can be effective and supportive

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The Board knew in the beginning that it was not possible to completely separate politics <sup>43</sup> Cassidy and Bish (156)

<sup>44</sup> Plumptre, Graham, 15

administrative mechanisms of local Band governance as long as Boards have a clear political mandate from the Chief and Council and the community through some form of legally binding instrument such as a Transfer Agreement providing a clear authority over financial resources.

3. That organizational structures need to fit the political environment. First Nations must have a particular political culture if a model such as the PBCN model is to work. The reality of First Nation organizations is to find ways to work with what some refer to as the elite culture of the Chief and Council who hold overall legal and political authority on reserve and to be able to accommodate the complex kinship orientations of reserve culture. Specifically, the Chief and Council must be willing to share power both formally and in the day-to-day pressure of politics. In the PB case, the strong overall support by all parties to separate health from Band administration in the Transfer helped give the Board independent financial control over the management of health funding and services, but it did not mean they were politically independent from the Chief and Council. Board accountability was structured into the organization by having the Portfolio Councilors sitting as ex-officio,<sup>45</sup> but non-voting members of the Board and community health committees.
4. Having standardized qualifications and selection processes for both Board and staff are important for gaining organizational efficiency and public credibility.

In the PB case, Board requirements were a flexible combination of both

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<sup>45</sup> Ex-officio means that because of their official political positions, Portfolio Councilors could be allowed certain membership access to the various Boards and committees in their portfolios

education and policy experience in community boards or committees. Having Board member advocates with a certain amount of personal credibility and profile in the communities helped gain public trust and legitimacy for the organization.

5. Having the Board supported by a skilled management team helps to better translate and implement Board plans and policies into workable administrative procedures and processes.<sup>46</sup> The management skills significant to the PB case were technical, human and conceptual. It was not enough for the managers to be technically qualified; they also needed effective interpersonal skills and the conceptual ability to resolve problems. Board policy required managers and staff to refrain from local politics and to maintain an arms length relationship with the Chief and Council in operational and funding issues. In the first few years in particular, even those managers who had technical capacity often had trouble reconciling corporate policies and political expectations especially in matters of staff discipline, hiring practices and finances. Eventually, as policy discipline became better understood and accepted, a more favorable advisory and informative relationship was worked out with less conflict in dealing with personnel and financial matters.

#### Power and Authority

- Legal frameworks and Agreements provide clearer delineation of power and authority

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<sup>46</sup>Institute on Governance, in collaboration with York University, CESO Aboriginal Services, Saskatchewan Indian Federated College, Understanding Governance in Strong Aboriginal Communities: Phase One, Principles and Best Practices From the Literature, Ottawa: Institute on Governance, October 12, 1999, 25



- Financial authority is essential
- Governance by policy and procedures are useful ways for coordinating roles and functions of the major players

#### Accountability

- Clear lines of roles and responsibilities are needed
- Board training was essential in areas of policy-making, budgeting and understanding financial records and conducting negotiations. Most were coordinated through the Executive Director through contracts with various training professionals such as accountants, lawyers and managers.
- Financial accountability is essential and requires adherence to financial control systems and qualified accounting staff
- Transparency in communications keeps key players informed
- Public meetings help generate health profile and public exchange
- Training and development were considered essential for developing the skills of the community staff in the health centers and much effort was put towards accredited training as a supplement to the workshops and conferences that were normally associated with training under MSB.

#### Relationships:

- Vision, purpose and work plans are important for coordination
- Board skills and profile help provide credibility and advocacy
- Knowledge of communities were important skills
- Local board and committee experience helps Board capacity

#### Political Culture:

- Community support is essential through the whole process
- Public access to information was important

- Local employment provided visible connection to the community because of language and family history

### Good Governance

What did this case study imply about the concept of good governance? One of the main ideas for designing good governance structures advocated separating the political and administration functions of government or in the case of corporate governance, between the functions of the Board of directors and the administration. In the case of First Nations governance, the same theme arose in much of the literature. In one review, the scholars concluded that "as a rule, the general management of development activities must not be the responsibility of political leaders. In fact, a separate organization can devote its complete attention to development, thus yielding higher results."<sup>47</sup> In a much quoted study by Harvard scholars, Cornell and Kalt on American Indian Development in March 1992, the conclusions suggested that successful Tribal businesses were those that had the appropriate power and authority to make their own decisions apart from the political tribal governments, who exercised that power through effective institutions and who had the capacity to make effective business decisions and policies. This meant clear and autonomous authority, organized institutions, and appropriately qualified decision makers. The findings of the Harvard study on tribal governance indicated that:

"As of 1990, these (18) tribes owned a combined total of 73 enterprises covering a wide range of sizes and activities, from agriculture to

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<sup>47</sup> Institute on Governance, in collaboration with York University CESO Aboriginal Services, Saskatchewan Indian Federated College, Understanding Governance in Strong Aboriginal Communities: Phase One: Principles and Best Practices From the Literature, October 12, 1999, 27. Website: [http://www.iog.ca/publications/strong\\_ab\\_gov.pdf](http://www.iog.ca/publications/strong_ab_gov.pdf)

manufacturing. A total of 39 of these enterprises were identified by their respective tribal leaders as being insulated formally from tribal politics, typically by a managing board of directors and corporate charter beyond the direct control of individual council members and the tribal chair. Some of these enterprises were operating profitably; others were losing money. However, the odds that an independently managed tribal enterprise was profitable were almost seven to one. On the other hand, the odds that a tribal enterprise that was not insulated from tribal politics was profitable were only 1.4 to 1."<sup>48</sup>

The literature findings of having separate power and authority structures between the administration and Chief and Council seem to be generally supported by the PB Health experience. However, it should be kept in mind that structural separation and financial control through the Transfer Agreement did not translate to political insulation from Chief and Council. The Board accommodated the political authority of Chief and Council by providing structural access through the Portfolio Councilors at the Board meetings and having them involved in the policy processes at all levels of the organization. What the literature and PB case study does not show is whether the reserve's population size, local culture and level of social crisis will influence corporate success even if an organization is separately funded and managed. But what the PB case provided which the literature does not is a birds-eye view into the actual structural mechanics and workings of a regional Board and organization in a certain political culture. What were some of these structural conclusions?

The literature review that was done earlier was unclear about what constituted good governance and there was no consensus around a common set of values or

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<sup>48</sup> Institute on Governance, in collaboration with York University CESO Aboriginal Services, Saskatchewan Indian Federated College, Understanding Governance in Strong Aboriginal Communities: Phase One: Principles and Best Practices From the Literature, October 12, 1999, 27, quoting Cornell, Stephen and Joseph P. Kalt, Reloading the Dice: Improving the Chances for Economic Development on American Indian Reservations, Harvard Project on American Indian Development, John F. Kennedy School of Government, Harvard University, March 1992, 35



principles which could be considered as having universal or general application.

Nevertheless, scholars have suggested some common themes that were observed in the PB Health experience. For example, the Institute on Governance in a policy brief identified 5 principles of good governance adapted from the United Nations Development Program.<sup>49</sup> These were:

1. Legitimacy and voice – public participation through institutional access, reaching a broad consensus in direction and where possible, policies and procedures.
2. Direction – strategic long-term vision and general plan to get there.
3. Performance – responsiveness, effectiveness and efficiency
4. Accountability – internal and external accountability to institutional stakeholders and public respectively, and transparency or free flows of information
5. Fairness – equity support by rule of law or legal frameworks especially those involving human rights

All of these principles imply a formalization of governance processes through some

form of legal institutional frameworks such as agreements, policies and procedures.

At first glance, the informal and more personalized tendencies of traditional governance seem to be at odds with the whole concept of institutionalized decision making. The Board was challenged to somehow merge the personalized caring associated with traditional society into their administration which they did by structurally defining power and authority, relationships and accountability between the key players and keeping abreast of the political culture through various

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<sup>49</sup> Graham John, Bruce Amos, Tim Plumptre, Principles for Good Governance in the 21<sup>st</sup> Century: Policy Brief No.15, August 2003, Ottawa: Institute on Governance, 2003, 3, 4

community surveys, conferences, and community health committees. Having annual policy and management reviews and making appropriate changes also built in a certain amount of flexibility to adapt to changes in both the internal and external environment

In one example, in response to community requests for more local control, the PB Board engaged in a management restructuring process. The local health coordinators became health directors supervised by the Executive Director rather than reporting to senior middle managers. Financial controls remained centralized, although budget developments and planning were done locally. The health directors were also integrated into the senior management team responsible for reporting to the Board and providing recommendations. Although this move did not necessarily prove to be a better and more efficient means of delivering services, the project provided a more manageable way for empowering local managers and health committees. In the broader society, the practice of governments is usually to centralize operations during crisis and decentralize during more stable conditions. In the PB case, management decentralization followed a conservative route occurring only after several years of operation and senior management mentoring.

Notwithstanding the many intrinsic factors associated with the PB Board's experience in management decentralization and the many other structural options that are available for distributing power and authority in organizations, some useful observations might be of general interest to those considering administration changes:

1. Start small and expand incrementally or in planned stages. Small steps are more manageable and adjustable to suit its environment.

2. Plan for the long-term future. Decentralization is a process and it takes time to see its benefits. Transparent planning, education and persuasion through inclusion are all necessary elements to make the transitions easier and less costly in the long run.
3. Plan to mentor the local managers. It takes time and much training to gain credibility, capacity and confidence in expanded roles. The risk is excessive supervision, lack of appropriate delegation and centralist paternalism – the savior syndrome. Clear delegation and work plans help.
4. Plan for formal and on-the-job training. Certifiable education is essential both in terms of managers gaining confidence and in having appropriate skills to do the job. Some decisions result in potentially unpopular political consequences whether in the local health centers or in the community. Training on the job helps by working through the implementation of policies and procedures to various situations as they arise.
5. Keeping key players informed is important because of changing roles and relationships. For local managers, it means taking on added responsibilities and being publicly accountable for local administration decisions. These are not easy and not always welcome. People like to make decisions but expect someone else to take responsibility for the consequences.
6. Start with small budgets. It provides more opportunities for successes in communities where managers are either not fully qualified or experienced in matters of administration. In the PB case, financial controls remained centralized, but local managers and health committees helped design their community budgets and were responsible for implementing the programs accordingly.

### **Topics For Further Study**

Some topics for further study arising from the PB Health experience could include:

- Further conceptual work in the area of 'good governance' and its constituent elements. Does good governance lead to better outcomes? There is much material on good management skills, strategies and institutional governance in the broader public administration literature, but their applicability to First



Nation and other Aboriginal settings is less certain. The PB experience implies the relationship between politics and business is a negotiated integration of both technical and political culture elements rather than the complete arms length separation normally associated with public governance and administration.

- Concepts of accountability, sustainability, representation and equity need further work in terms of the meanings and understandings between the diverse First Nation and Aboriginal communities. These are commonly used in government agreements and reports but interpretations often vary and are conflicting. In the PB case, the Board's emphasis was on fiscal accountability and stabilizing the organization through formal structures and procedures rather than solely relying on certain individuals to run the organization.
- Further work on the merits and disadvantages of community-run corporate organizations on reserves is needed. Will separate corporate structures undermine or enhance the power of the Chief and Council and their Band administration structures? What makes successful organizations? Should politicians be on Boards, and if so, in what capacity? More case studies would help. In the PB case, a combination of many things provided favorable outcomes.
- More work on concepts related to cultural appropriateness in service delivery. The meanings and perceptions of "holistic" or "cultural" are hard to define and have a wide range of interpretations and legitimacy. For some, sweat lodges, Medicine people, ceremonies constitute culture, for others it is less

visibly tangible referring to personal spiritual beliefs and family practices. In the PB case, the latter prevailed because of the largely Christian population, the practice of mixing both northern herbal remedies and western medicine and concerns with potential legal liabilities associated with refusing conventional treatment offered at the clinics.

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### Appendices

1. PBCN Health Services Inc. Organizational Chart. Prince Albert, Sask.: 2000
2. PBCN Health Services Inc. "Map" of PBCN Region. Briefing Note: Presented to Honourable Allan Rock, Minister Responsible for First Nations and Inuit Health Branch, August 3, 2001. Prince Albert, Sask.: 2001

## Peter Ballantyne Cree Nation Health Services Organizational Chart





